Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #16a,tchd,r1s,11/1/12 Amended Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHONER Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deatl Spital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Days Hours 218-48-5315 64 Director 1 **⊠** M 2 □ F 05-28-1948 Maryland Usual Residence of Decedent should be filed within 12 months and Mentai Hygiane.
I is marked other then "neturel", or items 23e or 28e-f showneste avent, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hurlock Md Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5011 Mt. Zion Road 21643 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Line Laeder Leader B&G Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lillian Dobson Floyd Henry Smith 1 and 2 should be of Health end Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 Department of Heaith Important: If Item 27 eny Injury or other tr Pamela Smith / wife 5011 Mt.Zion Rd., Hurlock, Maryland 21643 20b. Place of Disposition (Name of III.C cemetery, crematory or other place) Direct Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dover, Delaware 11-12-12 22. Name and Address of Facility Bennie Smith Funeral 516 S. Main St., Hurlock, Md. 21643 21. Signature of Funeral Service Home 23a. Part 1. En er the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ METASTATIL PROSTATE CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physicien: Tha lew requires thet the deeth certificete ba executed within 24 hours after death.

To the Funerei Director: After this certificate hes bean signed by the attending physicien and completaly filled in by the funeral director, page 2 should be detached for use es the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Pesidence} \) 1 \(\text{Conditions} \) 1 \(\text{Pecify} \) 1 🗌 Yes 2 146 မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natura! 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kramen MD D 00 66441 OCTOBER 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 Ramesh EALTON MD 2195 Kolli, 72 NOTPUHLLACH RS 3+1 VA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2012

DHMH 17 Rev 06-2011

Registrar

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Physician	1	egistrar . Decedent's Name (First, M			_			2. D	Pate of Death Nonth			3. Time of Death 1210 hrs
Medical Examine		HELEN C. SCHW		nber)	T	4b. City, Town, o	r Location of		ovember :	2, 2012 4c. County o	f Death	12101113
		Memorial Hospital				Easton				Talbot		40.
Funeral Director		5. Social Security Number 220–28–1242	1 M 2 X F	7. Age (In yrs. I		If Under 1 Yes Months Day		Min	03/07/	(MM/DD/YYYY 1932	Foreign	nplace (State or) NSYLVANIA
ıny	_	Jsual Residence of Deceden 0a. State 10b. Cour		10c. City,	Town or Loca	tion						10d. Inside City Limits
Maryland 28a-f show any datonce.	۱	MD TA	LBOT	COI	RDOVA							1 Yes 2 X No
the Maryland a or 28a-f sh iffied at once		0e. Street and Number				10f. Zip Code				g. Citizen of Wh	at Coun	try?
eath with the Maryland items 23a or 28a-f sho ust he notified at once nover an original processor.		10919 CHAPEL 1. Marital Status		dent Ever in U	.S. 13. W	21625 as Decedent of H		in? (Specify		USA 14. Race	- Americ	an Indian, Black,
र् हें हैं ।	Lane	1 Never Married 2	Married Armed For 1 Yes Divorced If Yes, Give Year			Yes, specify Cuba	an, Mexican,			White Specify:	•	E
ours af	<u>8</u>	15. Decedent's Education (or Dates: Specify only highest grade			nt's Usual Occupa			done	16b. Kind of Bu	siness/Ir	ndustry
2 - 7	Сощріете	Elementary/Secondary (0-	12) College (1-	4 or 5+)	HOMEM	•				PRIVATE	RES	SIDENCE
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Mid			<u> </u>		18.Mother's			aiden Surname		
21218 hould be fill ind Mental H is marked itic event, i	0 26	19a. Informant's Name/Relati	onship (Type, Print)			ng Address (Stre	eet and Num	ber or Rural	Route Numb			Zip Code)
MC all all ar ar and 2 si	-	LOIS J. MACDO		20b.	Place of Dispo	9 CHAPEI		Da		20c. Location -		Town, State
nore ages 1 and of H	-	1 X Burial 2 Crema		m State FA	EMETERY	7		11/08	/2012	CORDOV	Ά, Ι	(D
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the		4 Donation 5 Othe 21. Signature of Funeral Serv			FPF	Na In Own Syddre	ELFEN	BEIN	& NEWN			HOME, P.A.
Physician	+	23a. Part I. Enter the disease	e, or complications that ca	used the death		00 S. HAI						Approximate Interval Between Dnset and
/Medical		failure. List only one ca Immediate Cause (Final dise	ase a. Pulmonary									Death
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e be executed sysician and burial - transit	edical	UNPENDED	AMENDED									
8760, ifficate be ng physic as the bur		IF FEMALE: 35. Was decedent pregnant		outcome of preg rth		etal death 3	Ectopic	pregnancy		23d. Date of Month	,	ay Year
Box 6876(e death certificate the attending phy ed for use as the b	Physician/N	past 12 months? 1 Yes 2 No 9	Unknown g Unkno	ant at time of do wn	eath 5 0	Other (Specify)						
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Division of Vital Records, P.O. Is or Attending Physician: The law requires that it a site death. In John Charles or the confinence has been signed by led in by the funeral director, page 2 should be detactor.	Completed								24a. Was a autops perform	sy p		topsy findings available ompletion of cause of
tal Rec	팅				_	26 Pla	ce of Death	(Check only	1 ✔ Yes 2		✓ Ye	s 2 No
Vital Recystian: The linis certificate director, page	m	25. Was case referred to me examiner? 1 ✓ Yes 2 No		npatient 2	ER/Outpatier		Lou			Residence 6	Other	:
ing Phy After th funeral	<u>م</u>	27. Manner of Death		of Injury Day,Year)	28b. Time of	· · _	jury at Work		d. Describe h	low injury occur	ed	
Attend Attend or death ector: by the	Certification:	2 Accident	Pending Investigation 28e. Place	e of Injury - At h	nome, farm, str	eet, factory, office		1 1			er or Ru	ral Route Number, City
Divi	ertif	4 Homicide	Could not be determined (Specify)						or Town, St	tate)		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the bes	t of my knowled	dge, death occ and/or investig	urred at the time, ation, in my opini	date and pla on, death oc	ace, and due curred at the	e to the cause e time, date a	e(s) and manne and place, and o	r as state lue to the	ed e cause(s)
To the within 2 To the complete	Medical	29b. Signature and title of ce	and manner s	ated	0		nse number			29d. Date sign		
		ace	Cu.	A	U.	0.0	C.M.E.			November	3, 201	12
		30. Name and address of pe Zabiullah Ali, M.D.				Baltimore St	reet. Balti	imore. MI	D 21223			
RS 12 Sta	ite	31. Date filed (Month, Pay)		gistrar's Signa			,					
Registr		MITA	D ZUIZI	سيستعمين	14. 14	purce						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 10a-f per inf 936 2-25-13 vt State of Maryland / Department of Health and Mental Hygiene Amended 1- State Registrar #17, tchd, r1s, 11/1/12 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oct 22 Year Physician/ 7:56P M 2012 Karolyn Sanders Medical E. a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Talbot Genesis HealthCare The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 06/05/1942 KS. 513-42-4808 70 Director Usual Residence of Decedent 10b. County Cumberland show 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland at 10a. State Director NJ. Millville or 28a-f st notified -McDaniel 1 K Yes 2 K No MD. -Talbot 10e. Street and Number 1314 Goldfinch Lane 10f. Zip Code 10g. Citizen of What Country? 23a or 08332 pe Funeral U.S.A. 9380 Pennywhistle Drive $\frac{421647}{1}$ permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married arolyn Sanders Itimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ife. DO NOT use retired) Elementary/Seconday (0-12) own Home College (1-4 or 5+) Homemaker æ 18. Mother's Name (First, Middle, Maiden Surname) **Inga Rydell** 17. Father's Name (First, Middle, Last) ဂ္ Oscer -Swanson Oscar Swanson ... 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9380 Pennywhistle Dr. McDaniel, MD. Dean Sanders/ Husband altimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Delmar, DE. Crem. of Delmarva 10/25/12 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licensee Harry Ages Ostrowski Funeral Home P.A p.o. Box 518 St. Michaels, Md. Joseph C. F.S.A M. Ostizowski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final sician/ panclean disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any course is a sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 No 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued in the cause of the only one) 3 🗆 29b. Signature and title of certifier 10-24-2017 1)0070405 of person who completed cause of death (Item 23a) (Type, Print) Curtis Foy, M.D. 555 Cynwood Drive Easton, MD. 21601 31. Date filed (Month NOV Year) 1 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** November + Baltimore Randallstow 10spita . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F JUNE 29 Days Hours Min. Ountry) ALABAMA 417-80-8703 57 **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 X Yes 2 No **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 NORTHEAST AVENUE, APT 3B 21001 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 1973-75 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INDEPENDENT CONTRACTOR TRANSPORTATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DAN A. SCOTT, SR ALMA LEE PARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAN SCOTT, III (SON) 313 BRUSHWOOD DRIVE, OWINGS MILLS, MARYLAND 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State CASTWOOD MEMORIAL GRDS 4 ☐ Donation 5 ☐ Other (Specify) 11/16/12 MONTGOMERY, ALABAMA Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE 21. Signature of Funeral Service Licensee Dia MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e while. Approximate Interval Between Immediate Cause (Final disease or condition CCU Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year ned by the a cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2/☐ No Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be examiner?
1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide
Homicide Suicide Could not be in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) NOVEMBER 07 2012 DO06076TO son who completed cause of death (Item 23a) (Type, Print) 3+1VA F431 court road andalistour 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

		-	For State of Maryland / Department of Registrar Cer	tificate of Death		g. No. 20	38505		
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 10, 2012	3. Time of Death		
	Medic Examin	al	Robert W. Steele 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November	4c. County of Dear			
	LXanimi		69 Blakiston Lane	Warwick		Cecil			
23	Funeral Director		5. Social Security Number 185–38–1969 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	year) 9. Bir 958 PA	thplace (State or Foreign puntry)			
	/aryland 8a-f show tified at	rector	10a. State 10b. County 10c. City, Town or Loc Warwick	eation			10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	with the Ns 23a or 2	Funeral Director	10e. Street and Number 69 Blakiston Lane	10f. Zip Code 21912	10	ng, Citizen of What Co USA	ountry?		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Forces? If	Vas Decedent of Hispanic Origin? (Spr Yes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.		
1215-(thin 72 hou ine. than "natu ne Medica	Completed	(Specify only highest grade completed) (Give I Elementary/Seconday (0-12) College (1-4 or 5+)	ent's Usual Occupation vind of work done duning most of work O NOT use retired) C/Operator	ing	16b. Kind of Business			
Baltimore, Maryland 21215-0036	be filed wil ental Hygie ked other ic event, tt	6	12 2 Owner 17. Father's Name (First, Middle, Last) Norman E. Steele		e (First, Middle, Ma				
, Mary	d 2 should salth and M mar 27 is mar er traumat			g Address (Street and Number or Rur Lakiston Lane, Wai			p Code)		
imore,	Page 1 an ment of He ant: If iter ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Dispo	rematory 11/1: ices	3/2012	Newark,	DE		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee Venicent La Grand	Strano & Feelley I 635 Churchmans Ro			e 02		
	Priysician/ Medical Examiner	aminer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Colon Cance		2	Approximate Interval Between Onset and Death		
092	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.						
P,O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Physician/N		Ectopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year		
ds, P.O.	requires that the der been signed by the should be detached	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			o the cause of death? Probably 4 Unknown		
Division of Vital Records,	sician: The law rec s certificate has bee lirector, page 2 sho	Completed by			24a. Was an autopsy perform 1 \(\sum \text{Yes}\) 2	y prior to	utopsy findings available completion of cause of		
ital	sician: certifik irector,) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Chec		nce 6 🗆 Other (Spe	-16.1		
on of \	nding Physath. : After this e funeral di	icate: To	27. Manuer of Death 1. Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe hov		спу		
Division	tal or Attending is after death. al Director: After led in by the funer	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strabuilding, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,		
	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death of the control of th	tigation, in my opinion, death occurred a death occurred at the time, date and pla	t the time, date and ce, and due to the c	I place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.		
0	5 × 6 ©		29b. Signature and title of certifier	29c. License number Dook 21		Ed. Date signed (Mont	1		
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, F 2533 AUGUSTINE HERMAN HWY)	SUITE A, CHEST	PEAKECI	TYMD	21915		
	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	have					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19b per FH FCHD TM 11/9/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day 5 2012 0921 A M Eugene Orrie Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Home Care & Hospice Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) (Month, Day, Year) Days Hours Country 216-34-0233 1 M 2 D F Jan. 12, 1937 Maryland 75 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Mount Airy Maryland Carro11 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21771 4367 Ridge Road Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1960-1 ☐ Yes 2 ■ No Specify: Specify: 3 Widowed 4 Divorced White 1962 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) County Govt. Night Watch Man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary K. Herbert Henry G. Smith 19b4 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4267 Ridge Road, Mount Airy, Maryland 21771 Elizabeth L. Smith, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mountainview UMC Cem. 11/13/2012 Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specif 22 Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 21. Signature of M01393 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rubable Krosep315 Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying

Physician/ Medical Examiner

Registrar

10a. State

Director

Funeral

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Physician/

Examiner

Funeral

Director

permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If item 27 is merked other than "naturel", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner mention without anote.

Baltimore, Maryland 21215-0036

Medical

ettending physician end for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760

edical Exal	that initiated events resulting in death) Last	C. Due to (or as a consequence of): d					
by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		topic pregnancy ner (specify)		23d. Date of delivery Month Day Year		
ed by Pr		ontributing to death but not resulting in the under			ouse contribute to the cause of death?		
Completed	Lung can	cer		24a. Was an autopsy performed?			
Be	25. Was case referred to medical		26. Place of Death (Check	k only one)			
10 10	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other:	ome 5 🗆 Residence	6 NOther (Specify) In potient ury occurred Hospice		
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred Hospice		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)		
Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, death occuner: On the basis of examination and/or investigate Practitioner: To the best of my knowledge, dea	ion, in my opinion, death occurred a	t the time, date and pla	ice, and due to the cause(s) and manner stated.		
_	29b. Signature and title of certifier		29c, License number 29d, Date signed (Month, Day, Year)				

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ste. 204 Westminster

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Howard

31. Date filed (Month.

arke

226 Washington

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saiontz, m.D.

8 2012

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Novem Jerry Maxwell Sweeney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min Hours 214-42-1547 **Director** XX M 2 - F 68 Jan.20,1944 Maryland Usual Residence of Deceder 28a-f show filed within 72 hours after death with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1XXYes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral USA 240 Buena Vista Ave. 21740 ural", or items ! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", 3 Widowed 4XXDivorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Manufacturing Fabricator 10 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ٩ permit. Page 1 and 2 should be i Department of Health and Mente Important: If item 27 is marked Percy Maxwell Sweeney Hazel Lorraine Snapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16810 Tammany Manor Road Williamsport, MD 21795 Vicki Lowery - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation injury or 11-16-2012 Sharpsburg, Maryland Mt. View Cemetery Donation 5 - Other any inj 22. Name and Address of Facility Osborne Funeral Home, P.A. Williamsport, MD 21795 425 S.Conococheague St. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque ce of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and resulting in death) Last to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at id be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 1 No Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, n 24 hours after vector. After the roletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

IW-0 State

within 2

Registrar DHMH 17 Rev 06-2011 (Check

SHAHAD Date filed (Mor

29b. Signáture and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

gistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Dea Harry Victor Smith 11-15-2012 10:22a Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death Hagerstown 18411 Woodside Dr. 4c. County of Death Washington Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dav. 217-30-7132 9. Birthplace (State or Foreign Days Director 76 Hours Min. Day, 1 X M 2 🗆 F Usual Residence of Decedent 3-26-1936 MD or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-t show 10a. State 10b. Count Director 10c. City, Town or Location MD Washington 10d. Inside City Limits Hagerstown, 1 Yes 2 XNo 10e. Street and Number ms 23a or must be r 10f. Zip Code 18411 Woodside Dr. 10g. Citizen of What Country? Funeral 21740 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 No. If Yes, Give 1957 11, Marital Status the Medical Examiner Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black, White, etc. "natural", Completed 3 Widowed 4 Divorced 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates. 1963 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) state govt. 12th grade State Trooper 1 yr Be 17. Father's Name (First, Middle, Last) Harry Victor Smith Jr. 18. Mother's Name (First, Middle, Maiden Surname) Helen Hamburg 19a. Informant's Name/Relationship (Type, Print)
A. Carolyn Smith 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18411 Woodside Dr. Hagerstown, MD 21740 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11-20-1 X Burial 2 Cremation 3 Removal from State Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD Rocky Gap Veteran 2012 21. Signature of Funeral Service License 22 Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O. BOX 310 Clear Spring, MD 21722 Kai 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Longestive HearT Onset and Death Medical Examiner Sequentially list conditions Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) oronar resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery 1 Yes 2 No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hypoventilation of Obesity 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed To Be 25. Was case referred to medical examiner?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending work?
1 Yes ☐ Accident☐ Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check To the within 2 Certifying Nurse Practitions for the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

0. Name and address of person who

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31. Date filed (Month: Day Year)

P.O. Box 68760

Division of Vital Records,

use of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last, 2. Date of Death Physician/ NOVEMBER Medical Examiner vn, or Location of Death 4c. County of Death ALTIMORE 8. Date of/Birth (Month, Day, Year) August 28,1948 If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 218-50-2843 Hours Min. Director 1 XM 2 □ F 64 Maryland 10b. County 10c. City, Town or Location Director 10d, Inside City Limits ral", or items 23a or 28a-fs Examiner must be notified Maryland | Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14238 Shelby Circle 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2 🗓 No If Yes, Give Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Sales Manager Sign Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentel ဂ္ E. Rolland Strock Helen Frances Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47691 Sandbank Square Sterling, VA 20165 Christine Strock-sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 11-19-2012 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the discount of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Encephalitis Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif who completed cause of death (Item 23a) (Type, Print) JW-15

State Registrar 32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 7:52 PM Physician/ Blanche Melissa Shifler 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown Washington Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 171-28-5526 **Director** 1 🗌 M 2 🗓 F 77 Yrs Dec 17, 1934 Pennsylvania Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 💢 No Maryland Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 19228 Swinging Bridge Road 21713 Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Medical Examiner Armed Forces? 1 ☐ Yes 2 💢 No Black, White, etc. ō ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify White "natural", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bookeeper Retail event, the 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) and Mental His marked o ျှ Edgar Overcash Roy Blanche Crouse Overcash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Michael Shifler . / son 19139 Swinging Bridge Road Boonsboro, MD 21713 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 11/21/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, 21. Signature of Funeral Service Lice 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 No Yes 2 No certificate 26. Place of Death (Check only one) the funeral director. 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA . Manner of Death

1 Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 06-2011

31. Date filed (Mo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

			State of Maryland / Department / Department / Department / Department / Department / Department		Mental Hygiene	12 33511
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg. No U	3. Time of Death
	Physicia Medic		Ronald Sidwell		11/7/2012	Year 7:12 p M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. Count	ty of Death
_			2301 Pinefield RD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Waldorf If Under 1 Year If Under 24 Hrs.		arles
	Funeral Director	0	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1299 44 0451 12 M 2 F 65 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 07/06/1947	9. Birthplace (State or Foreign Country) OH
	and show lat	or	10a. State 10b. County 10c. City, Town or Lo.	cation		10d. Inside City Limits
	Maryli 28a-f otifie	Director	MD Charles Waldorf			1 🄀 Yes 2 □ No
	th the 3a or t be n		10e. Street and Number 2301 Pinefield Road	10f. Zip Code	10g. Citizen of	What Country?
	ems 2	Funeral		20601 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	ce - American Indian,
9	fter de , or it amine	by F	1 ☐ Never Married 2XXMarried 1 ☐ Yes 2 X No	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto		ack, White, etc.
Ö	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at	Completed	3 Wildowed 4 Divorced Year or Dates.	dent's Usual Occupation		y: White
21215-0036	ո 72 հա an "na Medic	mple	(Specify only highest grade completed) (Give I	ient's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16b. Kind of I	Business/Industry
2	l withii ygiene her th it, the		12 Auto	Mechanic	Priva	ite
Maryland	be filed tental Hygrked oth	To Be	17. Father's Name (First, Middle, Last) Arville Sidwell		e (First, Middle, Maiden Surnan Avo Bolin	ne)
aryi	should be file n and Mental I is marked of raumatic eve			ng Address (Street and Number or Rura		State, Zip Code)
Σ	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			Pinefield Rd.	Waldorf,MD	20601
Baltimore,	Page 1 a nent of H ant: If ite ury or oth			natory or other place)		- City or Town, State
iţi	permit. Page 1 Department of Important: If i any injury or conce.	9		ake Crem. 11/8 Name and Address of Facility Br		ville, MD
ñ	permit. Departn Importa any inju		M-10 /10 - // - 20.	294 Old Washing		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physical Medical	3 1	Immediate Cause (Final disease or condition resulting in death)	s of Ci	veen	Onset and Death
	Examiner		Due to (or as a consequence of):	0		
	_ =	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ecuted and I-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
09	death certificate be executed e attending physician and ed for use as the burial-transit	dical I	d.			
9/89	tificate	Med	IF FEMALE:			
Box 6	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		ate of delivery Ionth Day Year
		Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		
P.0	The law requires that the death certificat ate has been signed by the attending phagge 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		ntribute to the cause of death?
rds	equire een si hould	eted				3 Probably 4 Unknown
Records,	sician: The law r certificate has b lirector, page 2 s	Completed			autopsyperformed?	. Were autopsy findings available prior to completion of cause of death?
		Be Co	25. Was case referred to medical	26. Place of Death (Check	1 L Yes 2 No	1 L Yes 2 L No
Vital	ling Physician: After this certific funeral director,	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	ot 3 DOA Other: 4 Nursing Ho	me 5 Aesidence 6 Ott	her (Specify)
n o		cate:	27. Manner of Death T Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury 28b. Time of injury injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
Division of	Attendi er death ector: A by the f	Certificate:	2 Naccident Investigation 3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)		28f. Location (Street and Numi	ber or Rural Route Number,
2	pital or Attendous after deatleral Directors.				City or Town, State)	
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death of check only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred at	the time, date and place, and d	ue to the cause(s) and manner stated.
	To th within To th comp	<	29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)
	23		Maltin	179837	2 11	8115
	Br.		30. Name and address of person who completed cause of death (Item 23a) (Type, P	oad wa	MOST.	4010600
	Stat Registra		31. Date filed (Month, Day Year) 9 2012 32. Segistrar's Signature 9.	all		,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 28 Month Year Physician/ 6:10 AM 2012 cott Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPita Howard General olumbia 9. Birthplace (State or Foreign 8. Date of Birth Year If Under 24 Hrs. **Funeral** (Month, Day, Months 1 **x** M 2 □ F 54 205-38-6384 Nov. Hanover, PADirector Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director Columbia Howard 1X Yes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21046 9224 Pirates Cove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give SpecifyWhite "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) 12 US Corps of Engineer College (1-4 or 5+) policy oversight Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ည Kay Crouse permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Harold O. Sentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1108 Roosevelt Ave Hanover PA 17331 Kay Crouse Sentz Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/29/12 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State |Hampstead MD 4 Donation 5 Other (Specify) Cremation Inc. 22 Name and Address of Facility Little's FH 34 Maple Ave Littlestown PA 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Adenocaranoma 30 day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Securities like the cause if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown failure, rena 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Ves 2 No 1 Yes 2 No certificate hupertension To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was correferred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 2 🗹 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation ☐ Accident 6 ☐ Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46120 28, 2012 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 21044

State Registrar

DHMH 17 Rev 7/2009

10710 Charker

32. Redistrar's Signature

DeLeon 31. Date filed (Month, Day, Year)

OCT 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#19A per FH Certificate of Death State Registrar 11/16/12 AACO HEALTH DEPT. CMH 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Villiam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BURNIE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 6 Sex **Funeral** Min. 1 M 2 □ F Months Hours MD 3-24-1931 81 212-30-6098 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Evantural roust to rollified at once. 1 TYes 21 No Director Anne Arundel Millersville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21108 8404 Woodland Rd Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give 1954—
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 1954<u>–</u> 1956 1 ☐Yes 2 ☑No Specify altimore, Maryland 21215-0036 ģ White 3 Widowed 4 Divorced 16h Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) I be filed withir ntal Hygiene. Civil Engineer NASA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ William G. Stitz Mary D. Dulin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type. Print) Saurora Paye Stitz/Wife Sandra Stitz / Wife Pages 1 and 2 s ment of Health an ant: If item 27 is 8404 Woodland Rd. Millersville, MD 21108 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Nov. 13, 2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 22. Name and Address of Facility
Park Funeral Home
Barranco & Sons P.A. Severna Park Funeral Home
495 Ritchie Hwy. Severna Park, MD 21146
Approximate permit. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2□No 1 □ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 ER/Outpatient 3 DOA Hospital: 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State
Registrar

e and address of person wh

NOV 07 2012

Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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ADISON PARK DR

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kathleen Florence Spiessbach 2012 5:25 P M Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview South River Edgewater Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Country 078-16-7003 **Director** 1 🗆 M 2 🗗 91 09/28/1921 New York r then "naturel", or itsms 23s or 28e-f shows the Medical Examinar must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director New Jersey Ocean Jackson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Maryland Drive 08527 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 √ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygisne. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 1 end 2 should be filed w if Heelth end Mentei Hygi Item 27 is merked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James A. Sorahan Florence Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Spiessbach/Daughter 413 Fifth Street, Brooklyn, New York 11215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of I Importent: If Ite eny Injury or ot once. 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Teresa Cemetery 11/14/12 Summit, New Jersey 21. Signature of Jupetal Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) years Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury Due to (or as a consequence of): Examin ettending physicien end I for use as the buriei-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year been signed by the should be distached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 🗆 Yes 2 📉 o 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? r this certificete hes berei director, page 2 s' 24a. Was an autopsy
performed

Yes 2 1 ☐ Yes 2 ☐ No Division of Vital funerel director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 ☐ Yes 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) al or Atternative effer death.

erel Director: Affer thing filled in by the funer. 27. Manner of Death

1 Z Natural

2 Accident

3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel within 24 hours of To the Funerel In Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D29193 November 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Killian, 3169 Braverton St., #201, Edgewater, MD 21037

Registrar

31. Date filed (Month, Day,

			1 - State of Maryland / Dep. Registrar Cen	artment of Health and N	Mental Hygiene)			
	Physicia	n/	Decedent's Name (First, Middle, Last)		Date of Death 3. Time of Death				
	Medic Examin	al	Regulo Clenio Sison 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 5, 2012 7:02 P M	\dashv			
)	Examin	ei	Southern Maryland Hospital	Clinton	Prince George's				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)	٦			
	Director		577-98-2040 1		March 30,1954 Philippines				
	show	tor	10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits	٦			
	Mary 28a-f otifie	Director	Maryland Prince George's Fort Wash		1 ☐ Yes 2 K No	\rfloor			
	ith the 23a or st be r		10e. Street and Number 11406 Grago Drive	10f. Zip Code 20744	10g. Citizen of What Country? USA				
	eath w	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		Ⅎ			
98	fter de ', or it amine	by	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.) Black, White, etc. Specify: Filipino				
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7	l withii ygiene her th it, the		Z Compt	iter Technician	Data Processing				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Desiderio Sison	18. Mother's Name Amelia	e (First, Middle, Maiden Surname) Palaganas				
lary	should and M is mai		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)	1			
Σ,	ind 2 s lealth im 27 her tra	- 8			ashington, MD 20744				
Jore	ige 1 a nt of H t; If ite			matory or other place)	Date 20c. Location - City or Town, State				
altin	mit. Pa partme portan injury				2/2012 Clinton , MD rge P. Kalas Funeral Home,P.A	-			
m	permi Depar Impo any ir	- 1/2	111192	5160 Oxon Hill Rd.	, Oxon Hill, MD 20745				
a.	Physician/	ď	23a. Part / Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Interval Between				
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	Coronay anky Dr.					
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	oronky unity Dr.	slust.	-			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
	exectian an		resulting in death) Last Due to (or as a consequence of):						
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189	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	ļ			
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1	Country Countr	Month Day Year				
0	at the d by th detach		g Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	-			
S, F	uires th signe tid be o	ed by	End Stage Renal Disease on Hemodia	A CONTRACTOR OF THE CONTRACTOR	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Soro	w requisite peers	Completed	V	,	24a. Was an autopsy findings available prior to completion of cause of	٦			
Rec	The la ate ha	performed? death? 1 Yes 2 No 1 Yes 2 No							
ta	ician: certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		4			
<u>ک</u> (g Phys er this eral di	e: To	1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 🗆 DOA 4 🗆 Nursing Ho	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	-			
ou	anding sath. vr: Afte he fun	ficat	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 □ Yes 2 □ No					
VISI	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ξ	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.	4			
	he Ho lin 24 h he Fu	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at	t the time, date and place, and due to the cause(s) and manner stated	d.			
	North To 1		29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
J,	0/44		30. Name and address of parson who completed gauge of death (them 23a) (Type I	D0055120	Na 5, 2012	\dashv			
5	1, 10		30. Name and address of person who completed cause of death (Item 23a) (Type, I Richard Pilmer MD 132 & South an an	renne SE Snite 310	Washington DC 20032				
	Stat		Richard Pilmer mo ize south an an 31. Date filed (Month, Day Year) 07 2012 32. Regular's Signature S.	park		٦			
, t	Registra	ır	101	/		\Box			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 15: 25 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltiMORE 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. (Month, Day, Year) Director 218-74-9996 1 X M 2 D F 53 March 25,1959 Maryland permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinational Denotified 41 once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7213 East Sundown Court 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2X Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Fleet Management</u> Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Schatz Shirlee Greer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) isa Schatz / Wife East Sundown Court, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven 11/3/2012 Frederick, Maryland Stauffer Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused thook, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician LUNG INJURY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TRANSPLANT WE MARROW Sequentially list conditions, Examiner Due to for as a consequence off if any leading to immediate cause. Enter Underlying MYELOPIBROSIS death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use es the burial-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IE EEMALE. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No 9 | Unknown 9 Unknown The lew requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2VZ No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury **Division** work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier moms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEANS St., BALTIMORE, 01 MD.MS MORIF-ANNE SMIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

NUV

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#6, /perff, G934, 12/15/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 5, 2012 6:00 a M Smyre Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sanctuary At Holy Cross Burtonsville Burtonsville Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 240-20-4304 1 X M 2 X I F **Director** 90- 89 Yrs. 12-15-1922 Catawba, NC Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Completed by Funeral 20901 United States 321 University Blvd 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Black 3 🖾 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) DC Government Property Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Owen Smyre Vanda Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Omar Saleem/ Son 701 Castlewood Drive Largo, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-12-2012 | Brentwood, MD Ft.Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21, Signature of uneral Service 3401 Bladensburg Road Brentwood, MD 20722 Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Advanced Neuro Endocrine Tumor Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-trail Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) ed by the a detached f a I I Inknown are nas been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coronary Artert Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pulmonary Embolism autopsy this certificate has Diabetes Mellitus Type 2 1 Yes 2X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending iniury work?
1 Yes 2 No 1 X Natural Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D54347 11-06-2012 OVI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, MD 20910 Neeras Chopra 31. Date filed (Month 22. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Schemer Month Physician/ Helen 11:38P M 10 2012 Nov. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Co. Nursing & Rehab. Charles La Plata . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 88 Director 205-12-7879 1 🗌 M 2 🛛 F 01/24/1924 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director notified 1 X Yes 2 No Charles La Plata MD 10g. Citizen of What Country? 10f. Zip Code ō 10e Street and Number must be 23a United States Funeral 20646 10200 La Plata Rd. items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. . or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates Specify: White "natural" Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Own Home the Homemaker Be filed \ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ge 1 and 2 should be fil nt of Health and Mental : If item 27 is marked Murnane John Lawrence Harriett Margaret other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2200 Holly Oak Ct., Kathryn Ann Yorke/Daughter Waldorf, MD 20601 Department of He Important: If item any injure 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 11/19/12 MDVets. Cheltenham, MD 22. Name and Address of Facility Raymond Funeral Signature of Funeral Service Lice SVC., M01517 MD 20646 5635 Washington Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Hovance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and I-tran Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year for 5 Other (specify) been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in part I. þ Anaemia, Chronic nestension. 3 Probably 4 Unknown 1 Tyes 2 🗌 No Completed Congestive heart- Were autopsy findings available prior to completion of cause of 24a. Was an autonsy After this certificate has 2 **X**No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural Accident
Suicide Investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type Print) out on Blud, SteB, GlenBwine, mp, 21061

Registrar

2012

		1 - State of Maryland / Department of Health an Certificate of Death	nd Mental Hy	giene Reg. No. 2	112 38519			
Physicia Medic		Decedent's Name (First, Middle, Last) MARION TURNER	2. Date of De Month	Day	Year 3. Time of Death 5:06 A M			
Examin	er	4a. Facility Name (if not institution, give street and number) 1027 BUTTERWORTH LANE 4b. City, Town, or Location of E UPPER MARLBORG	0	4c. County	of Death PG			
Funeral Director		5. Social Security Number 579-26-3394 6. Sex 1	Min. (Month, Da	sate of Birth Nonth, Day, Year) -14-1919 9. Birthplace (State or Foreign Country) DC				
Maryland 28a-f shoo otified at	Director	MD PG 10b. County 10c. City, Town or Location UPPER MARLBORO			10d. Inside City Limits 1X☐ Yes 2 ☐ No			
h with the ns 23a or	Funeral D	102. Street and Number 1027 BUTTERWORTH LANE 106. Zip Code 20774		10g. Citizen of US	What Country?			
land 21215-0036 be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates. 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P 1 Yes 2 No Specify:	i? (Specify Yes or No- Puerto Rican, etc.)	Did	ee - American Indian, ck, White, etc. BLACK			
21215- Vithin 72 ho rgiene. Per than "nat t, the Medica	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) follege (1-4 or 5+) CLERK	f working		usiness/Industry ERNMENT			
Iryland 2 buld be filed wi d Mental Hygie marked other matic event, ti	To Be	17. Father's Name (First, Middle, Last) RUDOLPH HALL 18. Mother's MARY I	s Name (First, Middle, LOWE	Maiden Surnam	e)			
e, Ma and 2 shu Health an em 27 is ther trau		19a. Informant's Name/Relationship (<i>Type, Print</i>) ANITA HALL/DAUGHTER 19b. Mailing Address (Street and Number of 10120 CAMPUS WAY SC		MARLBOI				
Baltimor permit. Page 1 Department of Important: If it any injury or o		21. Signatur of Fugeral Service Licensee 22. Name and Address of Facility	2-3-2012 POPE FUNER	AL HOMES	TON, VA 5, P.A.			
Physician Medical Examiner		23a. Part f. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as can shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSION Due to (or as a consequence of):			Approximate Interval Between Onset and Death			
be e	dical Examiner	Sequentially list conditions, thank leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. END-STAGE KIDNEY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			te of delivery onth Day Year			
us, F.C.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the cause of death? 3 □ Probably 4 □ Unknown			
VITAI KECOITAS, ysician: The law requires is certificate has been sig director, page 2 should b	e Completed	25. Was case referred to medical 26. Place of Death (1 \(\text{Yes}	rmed?	Mere autopsy findings available prior to completion of cause of death? □ Yes 2 ☑ No			
hysicie this cer	P B	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ng Home 5 💢 Resid	lence 6 🗆 Othe	er (Specify)			
DIVISION OF VITAL RECORD TO the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be A Homicide detarined)	ow injury occurre	er or Rural Route Number,			
DIVI ospital or hours afte neral Dire y filled in k		building, etc. (Specify) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plants.	City or Tow	n, State)	er as stated.			
To the Howithin 24 To the Fu	Medical	only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and title of certifier 29c. License number	rred at the time, date a and place, and due to the	nd place, and due he cause(s) and m	e to the cause(s) and manner stated.			
10		5. Schui MP D51462		11-5-	12			
10 SM		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDITA SIKRI, M.D 6357 OXON HILL ROAD, OXON HILL, M.	MD 20745					
State Registra	~	NOV 0 7 2012 32. Registrar's Signature						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 20b per fh \$936 2-25-13 vt State of Maryland / Department of Health and Mental Hygiene 2012 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 112 25 PM Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Marylan University Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Hours 551-96-3927 1 □ M 2 🛛 F **Director** June 22,1930 France 82 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🕅 No Conowingo Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21918 Funeral 53 Windmill Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) AAFES, Aberdeen Proving Ground Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetic Consultant Aberdeen Should be filed with h and Mental Hygien 7 is marked other th Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Celestine Jega Barreau Jean Baptiste Desbourdes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Windmill Road, Conowingo, Maryland Michel J. Pasquier (son) Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Arlington National Eemetery 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia 12-7-12 4 Donation 5 Other (Specify) 21. Sign a ure of Funeral Service Licensee 22. Name and Address of Facility & Son Funeral Home, P.A. Maryland 21903-0766 Perryville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart fallure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physidian Hemorrhag Introcrania disease or condition Medica resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi): Exami burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 76

9 Unknown Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been signal funeral director, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 1 Donatient 2 ER/Outpatient 3 DOA ျ 1 ☐ Yes 2 ☐ ★ 6 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending ___vatural

Accident 1 🗌 Yes 2 \square No Investigation 6 🗌 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | 29d. Date signed (Month, Day, Year) 29b. Signature and title 2012 B 11 101 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South 22 Green 31. Date filed (Month, Day 32. Registrar's Signature State NOV 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3852 State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201² 1:05 P M John Gilbert Thomasson, Jr November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles 1206 Adams Court Waldorf Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 68 1**X**XM 2 □ F 215-44-7491 March 23, 1944 Wash. D.C. Usual Residence of Decede 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland at Director the Medical Examiner must be notified 1 Yes 2 ☐ No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 20602 1206 Adams Court USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner muonce. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 💢 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Gardner 10th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maude Virginia Phillips John G. Thomasson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Adams Court, Waldorf, MD. 20602 Ann Marie Ford/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Waldorf, MD. 11/11/12 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee MOOSFY 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No within 24 hours after death

To the Funeral Director; A

completely filled in by the f Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

29b. Signatur and title of certifier

30. Name and address of person

(Check

only one

who completed cause of death

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

		For State Registrar	State of Mary		artment of H tificate of D			giene (Z Reg. No.	2012	38522
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Exami	ner	44902 Blake Cree	,	4b. City, Town, or Location Valley I			n	40.0	St. Ma	
Funeral		5. Social Security Number 6. S		yrs. last birthday)	. If Under 1 Year	If Under 24 Hrs			9. Birl	thplace (State or Foreign
Director			X M 2 □ F	53 Yrs.	Months Days	Hours Min.	(Month, Day 08/22/			shington,DC
nd how	5	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation		00/11/			10d. Inside City Limits
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a or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?
th with ms 23 must	ner	44902 Blake Creek		1.0	206		-16 2/	1	USA	
or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 🌋 No	n U.S. 13. \	Vas Decedent of His Yes, specify Cuban	panic Origin? (S i, Mexican, Puer	to Rican, etc.)	12	4. Race - Ame Black, White	
ural",		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	Yes 2 No	Specify:		Sį	pecify: Wh:	ite
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ife, INTAILYIGHTU ZIZIO-0030 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7)			g Address (Street ar					_
and 2 Health em 2 ther t		Melanie Hicks/ I 20a. Method of Disposition		0b. Place of Dispo	20 Cox Dr	ive Mecl	nanicsvi		MD 200 ation - City or	659
Dallillor bermit, Page 1 Department of mportant: If it any injury or o		1 Burial 2 🖾 Cremation 3 🗆 4 Donation 5 DOTHER (Special	Removal from State	cemetery cren	ey-Gardiner e,P.A.Cremat	tory 11/			ardtow	
permit. Page 1 and 2 Department of Healtl Important: If item 2: any injury or other t		21. Sindature of Funeral Service Ligens			Name and Address Matt 1590 Fenw					
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-Physician/		stock, or heart failure. List only o Immediate Cause (Final disease or condition		r Cancer						Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a cor							
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eath certifica attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy				23	3d. Date of del	livery
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Atten r deat sctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury -	At home, farm, stre					Number or Rui	ral Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exami	sician: To the best of my kiner: On the basis of examinate Practitioner: To the best	nation and/or invest	igation, in my opinior	n, death occurred	at the time, date ar	nd place, a	ind due to the o	cause(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier		,	29c. License				signed (Month	
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(C) 10 110		30. Name and address of person who colored Jennifer Schmi	at 40900 Ma		rint) Ln, Leona	ardtown	MD 2065	0		
(5) RMU Sta						TTULUWILS	111 ZUUJ			
Registr		31. Date filed (<i>Month, Day, Year</i>) 14 2	U12 Serena	B. A.	acci					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b per FD AACO Health Dept. 11-13-12 KAH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10/29/2012 **Physician** 8pm Mary Esther Turek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold Future Care Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/18/1913 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 Hours MO 99 042-38-2266 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10h County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes XX No Annapolis Director Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 130 Hearne Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2√√No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married permit. Pages 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, Its Model Experimono. White Saltimore, Maryland 21215-0036 1 ∐Yes 2X2No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Gates Nathan Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 99 Harwood. MD 20776 daughter Joan Turek 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date IINK 20a. Method of Disposition ₩XBurial 2 Cremation 3 Removal from State Arlington, VA Arlington National Cem 12/17/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter order ying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown the Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to apath but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 🗹 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide f certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 0073574 use of death (Item 23a) (Type, Print) levy, Suite 204, Myllersville Name and address of person who completed cause of death (Item 23a) (Type, Print) Kan Mova 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 07 2012 gark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death and Canty Howa Cdun General Hospital If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours **Director** 160-32-8568 1 X M 2 □ F 74 10/07/1938 PA Usual Residence of Decedent er than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Ellicott City 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours efter death with 21043 United States 4614 Doncaster Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bio-Medical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h permit. Page 1 and 2 should be.
Department of Health and Mental Importent: If Item 27 is manal injury or other? မ Eva Katherine Wittig Eddie Allen Upright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4614 Doncaster Drive Ellicott City, MD 21043 Ruth Annette Upright - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 A Removal from State 4 Donation 5 Other (Specify) South Canaan Cem 11/17/2012 South Canaan, PA Signature of Funeral Service Lice 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Homas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause II Due to (or as a consequence of): Exami burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physicien: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Shack Sepsis Atrial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 🗆 Yes 2 🗆 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2017 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 21044 Deleon

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signatur

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	Funeral Director		5. Social Security No		Sex 7. Ag 1	Months Dave Hours						8. Date of Bir (Month, Da		9	. Birthp Count	lace (State or Foreign ry)
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	ted	3 Widowed		Year or Dates.					Specify:				Specify:		ite
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E.	sician: The certificate I rector, pag		25. Was case referre	ed to medical	1				26 Pla	ace of Dea	th (Check	1 Yes	2 N	lo 1 L	Yes	2 🗆 No
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	ical	29a. Certifier 1	Certifying Pl	nysician: To the best of	my knowl	edge, death	occurred a	t the time	, date and	l place, ar	nd due to the c	ause(s) a	and manner	as state	ed.
	the Ho hin 24 l the Ful mpletely	Medical			miner: On the basis of e urse Practitioner: To the											ise(s) and manner stated. tated.
	To the within To the comple		29b. Signature and	title of certifier				29	c. License	number			29d. Da	ate signed (N	lonth, [Day, Year)
	10+1		Cha	ruste f	aungent,	Phy	Meion		HOC	064	538		1	1/16/2	012	
	(LG)		30. Name and addre	ess of person whe	completed cause of c	leath (Item	23a) (Type, F	Print)	211	Blud	an	Hmore	11	D 11	22	1.
	(U) / Sta	te	31. Date filed (Month	1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	32. Registr	ar's Signat	ure	- 1		الالالا	Du	TIMOLE	1 M	0 24	(3)	0
	Registr			" WOV" 1 (ZUIZ Den	wa	A. ,	park	~							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38526 Certificate of Death 2. Date of Death Decedent's Name (First Middle Last) Month Physician/ 2012 11:55p.m^M James Joseph Vernere November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Min Director 1**X** M 2 □ F 149-14-3470 10/21/1925 New Jersey 87 Usual Residence of Deced 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a State 10b. County 10c. City. Town or Location Director New 1 Yes 2X No 0cean Brick Jersey 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 69 Catalina Drive 08723 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married 0 ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Garden State Parkway Supervisor other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Paterson James Vernere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau 466 Valmere Avenue, Piscataway, NJ 08854 /Son James Vernere 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
w Jersey
terans Cemetery 1 Burial 2 Cremation 3 Removal from State 11/16/2012 Wrightstown, NJ 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Si anno neral Service Licerser Feward N. Brinsfield 22955 Hollywood Road, Leonardtown, MD 20650 Jr. M00052 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. U Immediate Cause (Final ardiac Physician/ Dinalo disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events pertensa PRNERE and Due to as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ Director; After this 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending filled in by the 1 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.0 100 Leonardtown,

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registra Amend #28 Per FH JM 11/1 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10/2672012 1:00 P^{M} Angela M. Varona Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 11300 Acton Drive Waldorf Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 583-57-9333 1 □ M 2 🛛 F 87 Yrs 1/9/1925 Cuba Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Xyes 2 No PR San Juan San Juan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 00920 USA Escocia 370 Caparra Heights death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 ☐ No Specify: White If Yes, Give Year or Dates Cuban 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carlos de Varona Angela M. Abalo other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Evelio A. Gonzalez/ Son 11300 Acton Drive, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/8/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one call Onset and Death Immediate Cause (Final Physician/ ANCVER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 38 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ate has bage 2 s performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: Sons မ 4 Nursing Home 5 Acesidence 6 N Other (Spec 1 Inpatient 2 ER/Outpatient 3 IDOA this al Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Vatural work? 1 ☐ Yes 5 Pending Accident Suicide Investigation Vithin 24 hours are: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) e

Registrar

BIM

30. Marrie and address of person

31. Date filed (Month, Day

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who completed cause of death

		1	For State Registrar		State	of Mary	land / Dep Ce	artmen <i>rtificat</i> e			na IVIe		giene (Reg. No.	201	2	38528
Pi	hysicia	n/	1. Decedent's Name (First,		,						4	2. Date of Dea	ath	Yea	ar	3. Time of Death
	Medic Examin	al	Harry Dol					4b. City.	Town, or I	Location of D	Death	10/3)12 Year	eath	23:04 M
J.	-AGIIIII		Suburban	44					hes				1	Montg	om	
Dir	uneral rector		5. Social Security Number 216-74-52 Usual Residence of Dece		Sex I 🌠 M 2 🗆 F	7. Age (In) 8 2	yrs. last birthday, Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs 8 Min.	3. Date of Birt (Month, Dat 3/16/			Birthplace (State or Foreign Country) DC	
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with th	s 23a o ust be	Funeral Director	1701 EW H	wy Ap	ot T6				910				USZ		Odani	.,
036 s after death	Department of result and wented by the "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 3 □ Widowed 4 □ Di		12. Was Deci Armed Fo 1 Yes If Yes, Gir Year or D	orces? 2 X No ve	n U.S. 13	Was Deced If Yes, spec			n? (Speci Puerto Ri	fy Yes or No- can, etc.)		14. Race - A Black, W Specify: W	hite, e	te.
5-0 2 hour	"natur edical	Completed		Decedent's E ly highest gi	ducation ade completed)	(Giv	16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kir	nd of Busine	ss/Ind	ustry	
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Maryland 21215-0036 2 should be filed within 72 hours after Ith and Mental Hygiene.	arked oth	To Be	17. Father's Name <i>(First, M</i> Ernest J				- " '			18. Mother's Mir	s Name (First, Middle,	Maiden S Iord	ors		
Mary of 2 should salth and N	n 27 is ma er trauma		19a. Informant's Name/Re Chidi Ori			anage		ling Address	(Street ar 1 St	nd Number o	or Rural F Was	Route Numbe shingt	r, City or T	DC 20	Zip Ci 0 0	ode) 5
Baltimore, permit. Page 1 and Department of Hea	ant: If iten ıry or oth		20a. Method of Disposition 1 XBurial 2 Cre 4 Donation 5 (mation 3			Ob. Place of Disposemetery, cr Mt. Zi	ematory or o		" 1		Date 20c. Location - City or Town, State Baltimore, MD				
Balti permit. Departr	Importa any inju once.	İ	21. Signature of Funeral So		Bucon	CC03						I. Bac Washi				Home 0010
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760 ate be executed	y physician and as the burial transit	edical Examiner	Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s,	C		nsequence of):	_								
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To the within	100 E		29b. Signar re and fittle of	certifier IOM	inda	1	MD	290	License	number 3367				e signed (Me		
			30. Name and address of a Shyamsunda	ar Ra	jan 98	301 G	eorgia	Ave	#117	7 Sil	ver	Spri	ng,	MD 2	090)2
R	Sta Registra		31. Date filed (Month, Day, Year) NOV 07 2012 (32. Registrar's Signature)													

Harry Weaver 10/31/2012 2304 PM

			State of Maryland / Depa	rtment of Health and M	Mental Hygiene Reg. No. 2012 38529									
			1. Decedent's Name (First, Middle, Last)	modelo or Boden	Date of Death 3. Time of Death									
	Physicia Medic		Mabel Ward		Month Day Year 10 23 2012 1751 M									
	Examin		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death ${\tt Clinton}$	Prince George's									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 224–28–2473 91	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	. (Month, Day, Year) Country)									
	Director		224-28-2473		9-12-1921 Virginia									
	and show	tor	10a. State 10b. County 10c. City, Town or Local	ation	10d. Inside City Limits									
	Maryl 28a-f otifiec	irect	DC Washing	ton	1 🏝 Yes 2 □ No									
	h the	al D	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?									
	ms 2; must	Funeral Director	1820 Jackson Street, NE 11 Marital Status 12, Was Decedent Ever in U.S. 13. W	20018	USA scify Yes or No- 14. Race - American Indian,									
က	er dea or ite niner	by Fu	1 Never Married 2 Married 1 Yes 2 No	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	Rican, etc.) 14. Race - American Indian, Black, White, etc.									
8	ırs aft ural", IExal	ed t	3 ☐ Widowed 4 🖾 Divorced If Yes, Give Year or Dates.	Yes 2 K No Specify:	Specify: Black									
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupation ind of work done during most of worki	16b. Kind of Business/Industry									
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Baltimore, Maryland	1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	입	Roy Johnson	Florenc	e Davis									
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e,	and 2 s Health tem 27		Stephanie Johnson - Niece 12907 20a. Method of Disposition 20b. Place of Dispos		er Marlboro, MD 20772 Date 20c. Location - City or Town, State									
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atin	permit, Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21 Signature of Funeral Service Licensee	1n Cemetery !11/05 Name and Address of Facility Ft	5/2012 Brentwood, MD Lincoln Funeral Home, Inc.									
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200	ate be	Physician/Medical	d											
P.O. Box 6876	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery									
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ord	been shoul	Completed	Diabetes, CVA, MI, COPD, Breast Cand		24a, Was an 24b. Were autopsy findings available									
Sec.	he law te has age 2	dwo	Diabetes, CVA, MI, COID, Breade cans		autopsy performed? death? 1 ☐ Yes 2 ☑ No									
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Sio	Attenor death	Certificate:	2 X Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined determined 28e. Place of Injury - At home, farm, street		Fell at assisted living fac. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4801 Parkmont Ln									
Division of Vital Records,	al or safte		building, etc. (Specify) Assisted Living F		City or Town, State) 4801 Parkmont Ln Upper Marlboro, MD 20772									
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investignment.	ccurred at the time, date and place, ar										
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	55m		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint) 9135, PUC	at andery R' of \$100									
			ABULHASAN ANSMO, WI	Clipto	n Mg 2073									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month JEROLD DUDLEY WATERS November 12 2132 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 77 218-32-2698 1 X M 2 | F APRIL 8, 1935 MARYLAND Usual Residence of Deceden 10a. State 10b. County within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🂢 Yes 2 🗌 No MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 430 DORSEY STREET 21001 UNTTED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1955–57 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 🗆 Widowed 4 🔀 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 ASSEMBLY WORKER AUTO MANUFACTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any linjuy or other traumatic eveones. ည WILLIAM EDWARD WATERS, SR JEANNETTE ELIZABETH BRADLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN REDDICK / SISTER 430 DORSEY STREET, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ABERDEEN, MARYLAND HARFORD MEMORIAL GRDS 11/17/12 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GE 21. Signature of Funeral Service Licensee Lott- Coleman GRACE. MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hypoxic respiratory tallure Medical resulting in death) Due or as a consequence of Examiner aspiration phuemonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consequence of as the burial-transi Cause (Disease or injury that initiated events pulmonary edema Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death ☐ Yes 2☐ No be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ chronic obstructive pulmonary disease. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an congestive heart tailure autopsy After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Day. Year) RESCOO November 12, 2012 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+IVA Tittani Pittman, M.D. Lock Raven Bivd Baltimore MD 21239

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ovembe Physician/ ROSE ELLA WOODLAND 8:15 P.M Medical Examiner Facility Name (if not institution, give street and number) 4b. City/Town, or Lor of Death 4c. Coupty of Death Age (In yrs. 73 **Funeral** If Under 8. Date of Birth 9. Birthplace (State or Foreign MAY O' 579-54-7580 Months Days Hours Min **Director** 1 □ M 2 🔀 F MARYLAND 193 0a. State 10b. Count filed within 72 hours after death with the Maryland 10c. City, Town or Location
WHITE PLAINS 10d. Inside City Limits Funeral Director CHARLES MDor 28a-f 1 Yes 2 XX 10e. Street and Number
10546 CATALINA PLACE 10f. Zip Code 20695 10g. Citizen of What Country? UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iter edical Examiner 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X Specify Specify: BLACK If Yes, Give Baltimore, Maryland 21215-003 3 XXidowed 4 □ Divorced Completed Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working NAVAL BORDWANCE STATION (Specify only highest grade completed) MATERIALS HANDLER Elementary/Secondary (0-12) 1 2 TH College (1-4 or 5+) FEDERAL GOVERNMENT Be Father's Name (First, Middle, Last)
ROBERT POWELL 18. Mother's Name (First, Middle, Maiden Surname) and Mental VIOLA YATES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
936 RIFLE DRIVE, HENDERSON, NEVEDA 89002 19a. Informant's Name/Relationship (Type, Print) KEVIN L. WOODLAND, SR. (SON t: If item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 NOV . Date 12, ō 1XXBurial 2 Cremation 3 Removal from State POMFRET, MD Department Important: If any injury or 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee TERRENCE L JOHNSON FUNERAL SERVICE, 4433 WHITE PLAINS LANE, WHITE PLAINS, PA JOHNSON #M00993 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons sician and burial-transit that initiated events resulting in death) Last Due to (or as a con the attending physician Physician/Medical as the l IE FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy is certificate has been signed by the atterdirector, page 2 should be detached for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 🤻 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Fractitioner: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 201 30 Name and address of person who completed

State Registrar

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 A^{M} Welsh November 8:11 Gloria Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13998 River Rd. Newburg Charles 5. Social Security Numbe 578–28–0139 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) Davs Hours Min. **Director** 1 🗆 M 2 🔀 F 85 July 29,1927 VA Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director Charles · 28a-f Newburg 1 Tes 2x No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a Completed by Funeral 13998 River Rd. 20664 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 XMarried Yes 2XXNo Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 Thomas V. Neylan Adele Cataldo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston W. Welsh/Husband 13998 River Rd. Newburg, Md. 20664 if Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2xxCremation 3 Removal from State Brinsfield-Echols Crem. 11/8/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Arehart-Echols Funeral Home, PA 21. Sign re f Funeral Service Licensee MO0945 20646 Box 567 LaPlata, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Approximate terval Betweer shock, or heart failure. List only one et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leaving to immediate cause. Enter Underlying Due to (or as a consequence or). Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Ves 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕱 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License 30. Name and address of person ho completed cause of death (Item egistrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George E. Wood 2012 ar November .2:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall Mary's 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Days Hours Director 216-16-4905 1 😿 M 2 🗆 F 88 08/01/1924 Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 X No Maryland| Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1416 Alberta Drive 20747 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 👿 Widowed 4 🗌 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Joseph Albert Wood Avie Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Wood/Son 23 Florida Street, Dorchester, MA 02124 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State | 2 | Burial 2 | Cremation 3 | Bemoval from State | Resurrection | Cemetery | Cemetery | 1 | Donation 5 K | Other (Specify) | Entombment | Cemetery | 20b. Place of Disposition (Name of cemetery, crematory or other place) | 11/06/2012 Department of Important: If it any injury or o Clinton, MD 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 21. Signature of un 3 ard. Enter the discase, or complications that caused the death. Do not enter the mode of dy snock, or heart failure. List only one cluse on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 🗌 Yes

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certificate ompletely filled in by the funeral director, pag Certificate: To

Medical

Yes 2V No 25. Was case referred t medica 26. Place of Death (Check only one) examiner2 Other 1 🗆 Yes 2 No 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify, ER/Outpatient 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my Mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

signed\Month, Day, Year)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 11:20 AM Hiams Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 401 Dreams Landing Way Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 212-32-6885 Director 1 □ M **3**(√2) F 78 3/15/1934 Usual Residence of Dec 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director 1 Yes X No **Annapolis** Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a Funeral 401 Dreams Landing Way 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2XXNo Specify: White Specify 3 XXvidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only higher st grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Portrait Painting should be filed with and Mental Hygien 7 is marked other th Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Patrick Stack Laura May Gorman 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Edgewater RD. Pasadena, MD 21122 Leslie Sater daughter injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/7/2012 Meadowridge Memorial Elkridge, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 2.0 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or comp shock, or heart failure. List only of or complications that caused the death. Do not ter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betw anset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifiate signed (Month, Day, Year) veruher 05 2012

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State Registrar Name and address of person who col

31. Date filed (Month, Day, Year)

ath (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Physician/ Beamus Williams 2012 Ricky 1530 hrs October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 6. Sex **Funeral** (Month, Day, Year) **Director** 242-84-5926 1 🗶 M 2 🗆 F 63 March 19,1949 North Carolina Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Capitol Heights **Prince Georges** Maryland 10e. Street and Number 10g. Citizen of What Country? 0 ms 23a or must be i Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." 20743 United States 6012 Crown Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **X** No 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Parking Attendant Atlantic Garage 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ovel1 **Banks** Williams Clifton 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 Falkland Place; Capitol Heights, Maryland 20743 Charisse Yvette Williams 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Juneral Serv M0142 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown Yes 2 No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 No 11 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ၉ 1 🗌 Inpatient 2 🗶 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 🗌 Yes 2 🗌 No s after death.

I Director: A
d in by the f Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific , 2012 November D0061555 514 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) 3001 Hospital Drive M.D. Cheverly, Maryland 20785 Douglas D. Mayo, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5 2012 November Augusta E. Young 11:00 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab. Center Anne Arundel Edgewater 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Min Director 234-42-5158 1 □ M 2 🕅 F 07/04/1922 West Virginia 90 Usual Residence of Deced or then "neture!", or items 23e or 28e-f show 10a, State 10b. County within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3936 Germantown Road 21037 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Noah Lucas Mary Nelson permit. Page 1 and 2 should be Department of Health and Ment Importent: If Item 27 is marke eny Injury or other traumetic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4151 Carvel Lane, Edgewater, Maryland 21037 Charles D. Young, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Memorial Gardens : 11/07/2012 | Davidsonville, MD 21. Signatur of Funeral School pender 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final exebrovascular Disease Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transi Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 L 9 Unknown the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy 2 🔽 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) thin 24 hours after death.

the Funerei Director: After this mpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 00 11-06-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite B MAHBOOIZ urnie 31. Date filed (Month, Day, Year) State strar's Signature tack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2933 11-30-12 vt
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 5:30 PM Month November 23, 2012 Physician/ Norma Jean Anzio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12315 Timber Grove Road Baltimore Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 83 **Funeral** Months Days (どでせ ^D25 ear) 1929 [©]Pennsylvania 167-22-5697 Director 1 M 2 M F Usual Residence of Dece show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2 No Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21117 12315 Timber Grove Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married "natural", or ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed marked other than "naturation matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ware House Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Nell Simmons Gardiner Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tran Deborah Jaffa /Daughter 12315 Timber Grove Road Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 26 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 101443 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ mypertensive neo bro (clause wi disease or condition Medical resulting in death) Due to (s a consequence of) **Examiner** Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Day Month Yea Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an certificate has b firector, page 2 s prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Be Contract 1 Other: 4 Nursing Home 5 N Residence 6 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No eral Director: Ai filled in by the fu M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV TONSON Charles CT 6701 NI CHAMES ARNON 1 S 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

David	Robert	Attebery	
		4 .	

		1- For State Registrar	Certifi	icate of	Death		F	leg. No.	2012	35330	
Physicia		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death 1607 hrs	
edical Exami	ner	David Robert Attebery	-\		b. City, Town, or I	anation of Da	Novembe		2012 c. County of Death		
		 Facility Name (if not institution, give street and number 102 Virginia Avenue 	r)	4	B. City, Town, or i	Location of De	atn		1		
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6		10a. State 10b. County	10c. City, Tow	vn or Locatio	on					10d. Inside City Limits	
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MD 21215-0036 and 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	_	Susan Attebery Nicholas/S	ister 8	3709 н	eather F	Ridge C	Court, Gai	the	rsburg.M	arv1and 20879	
ore, MD 21215-003 stands should be filed within of Health and Mental Hygiene. If them 27 is marked other the traumatic event, the Med		Susan Attebery Nicholas/S	Crem	natory or oth	er place)		Date	20c.	Location - City or	ary1and 20879 Town, State	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	OTCH	22. Na	ame and Address	of Facility R	bert A.	Pum	phrey Fu	neral Home/ Avenue	
E F G B W		Land See S.A.	M0033	5 I Ro	ockville	Mary.	Land 2085	00-2	.805	Avenue	
Physician		23a. Part I. Enter the disease or complications that cause failure. List only one cause on each line.	ed the death. Do	not enter th	e mode of dying,	such as cardia	ac or respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and	
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760, icate be physical the burn	Med	IF FEMALE: 23c. If yes, outc	ome of pregnanc	cy				23	3d. Date of deliver	y	
687 ertific ding p	-	23b. Was decedent pregnant in the past 12 months?		2 Fet	al death 3 [Ectopic pre	gnancy		Month	Day Year	
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown g Unknown	at time of death	5 Oth	er (Specify)						
the d	Phy	Part II. Other significant conditions contributing to dea	ath but not result	ting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
Division of Vital Records, P.O. Box 68' at a ratending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	by	Atherosclerotic Cardiova	scular	Diseas	se		1 🗌 Ye	s 2	No 3 Pro	bably 4 🗹 Unknown	
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Division pital or Attencours after death eral Director: filled in by the	Certification:	4 Homicide determined (Specify)	Fd: P	rivat	e dw elli	ng	Rockvi	lle,	MD.	nia Ave.	
e Hos 124 h e Fun etely		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, d	death occurr	ed at the time, da	ite and place,	and due to the cau	use(s) a	nd manner as stat	ed.	
Division of Vital Records, P.O. Box 68" To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending completely, filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of exam and manner state	kamination and/o d.	or investigati			ed at the time, date				
1	Σ	29b. Signature and title of certifier			29c. License				Date signed (Mo		
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nx V			Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
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		1. For State Registrar		tificate of L	Death			. No. 201				
Physicia ledical Exami		Decedent's Name (First, Middle,Last) T	-	Reed			2. Date of Death Month November 2	Day Year	3. Time of Death 1904 hrs			
		4a. Facility Name (if not institution, give stree	t and number)	4b	. City, Town, or Lo	cation of Death	140Verriber 2	4c. County of Deat				
		201 Kuethe Road			Glen Burnie			Anne Arunde	<u> </u>			
Funeral Director		5. Social Security Number 6. Sex 1 M :	7. Age (In yrs. Ia	ast birthday) 27 Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	rthplace (State or gn puntry) MD				
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	1			10d. Inside City Limits				
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Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 in injury or other traumat		20a. Method of Disposition 1	tery, Y 11/3	Date 30/12								
Balti permit. Departu Imports		21. Signature of Funeral Service Licensee	ma s	22. Nar	ne and Address of	Facility Huk	bard Fu ne Balti	neral Home more, MD 2	Inc.			
Physician /Medial		23a. Part I. Enter the disease, or complication failure, List only one cause on each line	ns that caused the death.	Do not enter the	mode of dying, su	ch as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and			
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X = 2 = 1	Physician/Me	1 Yes 2 No 9 ✔ Unknown 9	Pregnant at time of dea Unknown	othe	(Specify)							
i, P.O. Bo ires that the deat signed by the at I be detached for		Part II. Other significant conditions contri	buting to death but not re	sulting in the und	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
S 'go S	ed by								bably 4 🗹 Unknown			
tal Records cian: The law requi certificate has been ector, page 2 should	Completed						24a, Was ar autopsy perform	prior to	utopsy findings available completion of cause of			
Rec The	5	or w					1 ✓ Yes 2	No 1 ✓ Y	es 2 No			
Vital hysician:	Be	25. Was case referred to medical examiner?	l: 1 Inpatient 2	ER/Outpatient 3		Death (Check or		esidence 6 🗸 Othe	er: Scene			
ding Phy. After th	n: To	1 ✓ Yes 2 No 27 Manner of Death 28		28b. Time of Inju				w injury occurred				
sion ttendi death. ttor: /	1 X Natural 5 Pending (Month, Dey,Year) 1 Yes 2 No											
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	27. Manner of Death Sec. Injury 28c. Injury at Work? 1 Yes 2 No No No No No No No											
To the Hospital within 24 hours. To the Funeral		29a. Certifier (Check only one) 2 Medical Examiner: On the										
To t With To t	Medical		nanner stated.		29c. License n			29d. Date signed (Mo				
7		11/1/		11	0.С.М.	E.		November 26, 2				
Ø	ŀ	30 Name and address of person who comple			<u>H</u> !		111_					
			tant Medical Exam		/. Baltimore St	treet, Baltimo	ore, MD 212					
St: Regist	ate rar	31. Date filed (Month, Day Year) 32. Resistrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris F. Bradley 10:35 A.M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Lorien Columbia Healthcare Center Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 213 28 0174 1 □ M 2 1 F 95 01/09/1917 Maryland Usual Residence of Decedent or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wedleal Exprement must be notified at 10c, City, Town or Location 10d. Inside City Limits Directo Maryland Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 10734 Evening Wind Court U.S.A. 21044 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married within 72 hours efter δ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Real Katherine Bray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth a ltem 27 i Carol B. Figueroa / Daughter 10734 Evening Wind Court Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportent: if ite
eny injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 11/14/2012 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the buriel-Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed cate has been significated to page 2 should to 1 ☐ Yes 2 √ No 3 ☐ Probably 4 ☐ Unknown 24a. Wasan Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 K No this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 🛣 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After t 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A completely filled in by the f Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospitai Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) Novenh 12 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aliu.....
31. Date filed (Month, Day, Year)
ANDLY 3 0 2012 6334 Cedar Lane Andrew Lazris Columbia, Maryland 21044 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Vivian G. Bailey 04:55 PM November 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Genesis Hammonds Lane Center Brooklyn Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 08 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Year) 1923 Days 1 □ M 2 💢 F 89 Yrs. 212-28-2329 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Medical Evantors must be notified at Director 1 ☐ Yes 2X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7913 Della Rosa Court 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2X No White þ Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental 27 Is marked ၉ Walter G. Adams Ethel F. Boqan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. Patricia Gretsinger (daughter) 7913 Della Rosa Court, Pasadena MD 21122 e of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of ∤ 01 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2012 Elkridge, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or composhock, or heart failure. List only o Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line Immediate Cause (Final **Physician** ear disease or condition resulting in death) /Medical br as a consequence Examiner Sequentially list conditions cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2 No 2 🗆 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2 (No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 A latural 5 Pending s after death. 1 □Yes 2 □ No investigation 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatu and title of gertifier 29c. License number npleted cause of death (Item 23a) (Type, Print) NO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Basil November 30 Jr. 20⁴2 12:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pasadena Anne Arundel 783 Woods Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1946 212-52-3291 sept 17 Country) Director 1**X** M 2 □ F 66 Yrs MD ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 783 Woods Road 21122 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highe st grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Route Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Knadler Basil Doris Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 783 Woods Road, Pasadena, MD 21122 Phyllis Basil (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 30 Baltimore, Maryland 2012 21. Signature of Fugeral Service Lie 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ CARCINOMO GASTric disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exempts) Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2. performed 2 🗆 No 1 ☐ Yes 2 🗹 No 1 🗌 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMON 5450 KNOLL North Ar

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November November Jeffrey ^D28,2012 Blair C. 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore 2628 Plainfield Road Dundalk 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 12,1956 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign Months Days Hours 213-70-4564 Director 1 ፟ M 2 ☐ F 56 Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2628 Plainfield Road 21222 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Narried þ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🛣No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Je filed with: ∼tal Hygiene. ✓er than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) years Manager Lumber Yard Be 17. Father's Name (First, Middle, Last) of Health and Mental Health and Mental Health and Mental Health and Term 27 is marked of rother treumatic even 18. Mother's Name (First, Middle, Maiden Sumame) မ Charles Henry Blair Shirley Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Blair Wife 2628 Plainfield Road, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any Injury or or on once. December 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, Maryland 1, 2012 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature of Fune al Service Licensee ²²Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Menon 23a. Part 1. Enter the disease, or complications that caused the de .m. L. not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an The law performed this certificate 2" No e Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certificietely filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending injury Division 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely To the I within 2 only one) 29b. Signature and title of certifie D0021859 t.mD MTU 28/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIPPING Pl Baltimore MD 2/222 TAVIMD 10 V 23 MOHAMMAD 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 28 Physician/ 2012 Patricia Ann Bryan November 7:04 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery General Hospital Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) **Director** 579-48-7289 1 □ M 2 XF Yrs 79 25, 1933 Washington, DC Apr. show with the Maryland be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Montgomery Sandy Spring 1 Yes 2 X No oř 10e. Street and Number 10f. Zip Code .s 23a o. 10g. Citizen of What Country? Funeral 17330 Quaker Lane, E18 20860 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced If Yes, Give Year or Dates Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the event, th Clerical 12th Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I and .

of Health and tem 27 is mark.

or traumatic events မ Francis Joseph Paxton Frances Deborah Gramm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Willmott/Daughter 9903 Rogart Road, Silver Spring, MD 20901 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Union Cemetery 12/2/2012 Burtonsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part 1 Enter the dis shock, of heart failu Immediate Cause (Final ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Pulmoner Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Myo cardial Sequentially list conditions, Due to (o a consequence of) if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician I for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year detached the g 🗌 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending the Accident Investigation 3 Suicide 4 Homicide 6 Could not be ģ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical

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the

H. WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Akhondi Als, Hossein State

29b. Signature and title of certifier

29a. Certifier

D 62167

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20010

29/12

Suite 2A-38E Washington, DC

110 Irving Street, NW Registrar's Signat

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No4 1. Decedent's Name (First, Middle, Last) Physician/ MON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emeritus at Pikesville PIKESVILLE Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 212.22.8782 Months Days (Month, Day, Year) Director 1 🗆 M 2 🔀 F Yrs 09/13 1921 MD 28a-f show 27 is marked other then "netural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Battimore Baltimore MD 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Charleswood 21207 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 end 2 should be filed within 72 hours after ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 end 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other then "eny Injury or other traumatic event, If a Menos. Once. College (1-4 or 5+) Elementary/Secondary (0-12) Electronic Hn arade Worker Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) ပ္ Wallace 19a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charleswood oan. Baltimore MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 125 2012 Windsomill 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C. Greene Funeral services andalistown MD 21133 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use es the burial-transit Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No Pregnant at time of death 5 ☐ Other (specify) Month 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 2 No. Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Mann 1 Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

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Registrar

DHMH 17 Rev 06-2011

and address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Bachu Yusab 14:21 Ismail 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre De Grace 1108 Bern Drive If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 06 26 Africa 108-50-8964 42 **Director** 1 XM 2 🗆 F 70 show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Havre De Grace be notified 28a-f Harford MD 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with U.S.A. 21078 must 1108 Bern Drive items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 'natural", or þ 1 Yes If Yes, Giv within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Indian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than N/A College (1-4 or 5+) life. DO NOT use retired) Elementary/Secondary (0-12) N/A Auto Shop Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aisha Yusuf Bachu ၉ Yusuf Bachu permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 Bern Drive, Havre De Grave, Md 21078 Department of Health a Important: If item 27 is any injury or other tran Mohamed Bachu-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Park 11/25/2012 Woodlawn, Md 4 Donation 5 Other (Specify) <u>Memorial</u> 21. Sign yur of Funeral Service Licenses March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc , or heart failure. List only one cause on each line. Interval Between Onset and Death Immediat Cause (Final disease condition resulting i death) Phyllician/ Medical Due to (or as a onsequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death the Unknown 9 Unknown P.0. signed by t Id be detach contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No this certificate Yes 2 No director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: A 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of

30. Name and a

smail.

tyress of person wbgcompleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November ^D20, 2012 Physician/ 1:10 Kenneth Η. Bergmann Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Rockville Collingswood Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) 578-30-6316 Director 1 X M 2 □ F 84 October 31, 1928 Washington, D.C. i Hygiene. I other then "natural", or items 23a or 28a-f show vent, tre Medical Examinar must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 13013 Freeland Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced White Completed WWII Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Real Estate t. Page 1 and 2 should be filed with the property of Health end Mentel Hygien thant: If Item 27 is merked other in Jury or other traumatic event, In Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Prosie Herman Bergmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13013 Freeland Road, Rockville, Maryland 20853 Irene M. Bergmann / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State November Parklawn Memorial Park Rockville, Maryland 4 Donation 5 Other (Specify) 24, 2012 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Meditte Day M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial Innerel Innerel Innerel Jeroch. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes 2, ₹ N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending 1 T Natural 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check The Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year, November 21, red cause of death (Item 23a) (Type, Print) 30. Name and address of person who come

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3 0

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, per fh, g936 2-5-13 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** BYRI 0630 NCILLE NOVEMBER 20 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOPLIN STREET **BALTIMORE** N/A Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 89 1□M 2XF Yrs. VIRGINIA Director MARCH 24,1923 <u>236-38-8168</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at 1

Yes 2□No MD. BALTIMORE N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 JOPLIN STREET 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No !f Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 10TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hill Important: If item 27 is marked ottany injury or other treumatic even Be ROBERT S. KIRK CORA LEE ADKINS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DTR. PHYLLIS NOVAK 302 JOPLIN STREET BALTIMORE, MD. 21224 20b. Place of Disposition (Name of competery, crematory or other p Oak Lawn Cemetery Louden PARK Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-19-2012 ^ 4 ☐ Donation 5 ☐ Other (Specify) 11-29-2012 BALTIMORE, MD. 22. Name and Address of Facility CHARLES S. ZEILER & SON INC. 21. Signature of Funeral Service License 6224 EASTERN AVENUE BALTIMORE, MD. 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNG CANCOR **Physician** MONTH /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of Injury that initiated events Due to (or as a consequence of). Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ▼No 9 ☐ Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown DISEASE ARTERY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 21500 1 🗌 Yes 1 Tes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier

within 24 hours a To the Funerel [0

State Registrar

HAYASH JENNIFER 31. Date filed (Month, Day, Year)

NOV 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, MD. 21224

5200

32. Redistrar's Signature

or 28a-f show

Items 23a

"natural', or

and Mental Hygiene. Is marked other then

filed within 72 hours after

certificate be executed

Division of Vital Records, P.O. Box 68760

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After

death.

o the Hospital or Attendi thin 24 hours after death. The Funerel Director: A

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PARKWAY PERRING BALTEMORE BALTIMOR Conten Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 215-30-8427 77 **Director** 1 □ M 2**X** F AUGUST 13,1935 **MARYLAND** Show 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a **IISA** 3041 FLEETWOOD AVENUE Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. WHITE If Yes, Give Year or Dates "natural", Specify Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Sec 12TH /Secondary (0-12) College (1-4 or 5+) LAW LEGAL SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even ဂ္ WILLIAM H. CHRISTIAN SR. TILLIE MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a: If item 27 i TRACY BOSSLE DTR. 3041 FLEETWOOD AVENUE BALTIMORE, MD. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2012 | BALTIMORE, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. ture of Funeral Service Licensee Sign Lavie NOTTINGHAM, MD. 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician ALZHEIMER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 本3 Division of Vital Records, P.O. Box 68760 as the ed by the attending detached for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Tyes 2 NO 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 \square No Investigation completely filled n by the 24 hours after deal Funeral Director 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5217 30. Name and address of person who comp EREC ANAPOLLUM cause of death (Item 23a) (Type, Print) vho complete 6095 MARSH 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

Registrar

NOV 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 12 Physician/ 3:38 RM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SAINT AGNES HOSD ITAL BALTIMORE If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min NONE **Director** 1 **X**M 2 □ F 0 MARYLAND November 12, 2012 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No It more Maryland and Number 10g. Citizen of What Country? Funeral Chipper 21244 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Was Decedent 2 Armed Forces? 1 Yes 2 No 14. Race - American Indian Black, White, etc. by 1 X Never Married 2 Married "natural", or 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Mada (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) non-e None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Badham Jenifer Clarice Wallace Darryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Badhan 7902 Chipper Road Boltimere, Maryland mother 20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHEORAL CEMETARY MAY 03, 2013 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BACTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOSPITAL GNES 900 CATON AVENUE BAUTIMORE, MARY Long 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence o Examiner Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of): if any, leading to immediate

Cause (Disease or injury executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? signed by the atte Month Day Pregnant at time of death 2 No 2012 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 12 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? Yes 2 No 24 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ပု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death ,28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check eath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, de only one 29b. Signature 1nd title of certifier 29d. Date signed (Month, Day, Year) D0059127 MD 2012

Registrar DHMH 17 Rev 06-2011

State

Garner

0

with completed cause of death (Item 23a) (Type, Print)
arner 900 Caton Avenue Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year NOVEMB27 2012 21:12 **Physician** GERALDINE BELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) 6-18-1932 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 80 MARYLAND 216-30-6193 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show at 1 Yes 2 No Director MD BALTIMORE ROSEDALE notified 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number with ò Examiner must be 8310 BERKFIELD ROAD 21237 U.S.A. "natural", or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of GERALD KRESS ELIZABETH ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health at Important: If Item 27 is any injury or other trau JAMES EARLE BELL/HUSBAND 8310 BERKFIELD ROAD ROSEDALE, MD Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL MEMORIAL 11-30-12 MIDDLE RIVER, MD

22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Injuly that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical The law requires that the death certificate be the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) page 2 should be detached P.O. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 □ No 1 ☐ Yes 1 Tyes 2 400 or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manne Death within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28f. Location (Street and Number or Rural Route Number, 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 27,2012

State Registrar

DHMH 17 Rev 1/2001 11595 32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011/08

0 2012

31. Date filed (Month, Day, Year)

NOV 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

heresa Karen	Ban	dalos S 1- For State Registrar	tate of Maryla		artment of rtificate of		d Mental H		Reg. No. 20	12 3855			
Physici Medical Exam		Decedent's Name (First, Mid Theresa Kar		105				2. Date of De		3. Time of Death 1730 hrs			
		4a. Facility Name (if not institut	ion, give street and nur	mber)	1	4b. City, Town, or I	ocation of Dea		4c. County of	Death			
		Franklin Square Hos	·			Rosedale			Baltimore				
Funeral Director		5. Social Security Number		7. Age (In yrs. l	ast birthday)	If Under 1 Year Months Days	If Under 24H Hours Mi	_	Foreign				
Director		218-74-4647	1 M 2 X F		47 Yrs				1/1965	country) Maryland			
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Locati	on				10d. Inside City Limits			
	5	MD Free	derick	Fr	ederick					1 X Yes 2 No			
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?			
th the Maryland 23a or 28a-f sho notified at once.	ΙĎ	1210 Little B	rook Drive	, Apt.	J .	21702		·	U.S.A.				
th wit	Funeral	11. Marital Status 1 Never Married 2 X		edent Ever in U. rces?		s Decedent of Hisp es, specify Cuban,			American Indian, Black, etc.				
ter de:			1 Yes	2 X No		Yes 2 X No		Specify:					
15-0036 filed within 72 hours after death with the Maryland Hygiene. do other than "matural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	d by	15. Decedent's Education (Sp	or Dates:		16a. Deceden	t's Usual Occupati	on (Give kind of		16b. Kind of Busi	White ness/Industry			
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0036 within 72 piene. ner than '	E D	12			Ca	shier			Reta	i1			
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and 2 shou lealth and M		John Bandalos	/ Spouse		- 1				J, Freder	ick, MD 21702			
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Baltimore, permit. Pages I ar Department of Hes Important: If ite		21. Signature of Funeral Service	e Licen	- file		ame and Address			Gifts Re				
Physician		23a. Part I. Enter the disease, o	or complications that ca	used the death	Do not enter th	22 Conne	lley Dr	., Ste.	P, Hanov	er, MD 21076			
/Medical		failure. List only one caus	e on each line.					or respiratory a	rest, shook, or hear	Between Onset and Death			
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Box 6876(c death certificate the attending physelfor use as the b	Physician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live bit	rth	2 Fet	al death 3	Ectopic pregr	ancy	23d. Date of do Month	Day Year			
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ding Ph		27. Manner of Death 1 X Natural 5 Death		of Injury Day,Year)	28b. Time of Ir			28d. Describe	how injury occurred				
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Division of Vital Records, P.O. rel ar Attending Physician: The law requires that the starter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	dete	ald not be 28e. Place (Specify)	ilding, etc.	28f. Location or Town,		or Rural Route Number, City						
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Division of Vital Records, P.O. Box 6876. To the Hospital ar Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	edical	one) 2 Medical Exa	aminer: On the basis of and manner sta	f examination ar	nd/or investigati	on, in my opinion,	death occurred	at the time, date	and place, and due	e to the cause(s)			
FRES	¥	29b. Signature and title of certifi		atou.		29c. License	number		29d. Date signed	(Month, Day, Year)			
		Tamile Weath	all mi)			O.C.N	1.E.		November 2	3, 2012			
	1	30. Name and address of person Pamela E. Southall, I	· ·	,	,	M/ Politima	Ctroot Del	imaro MD C	1222				
	ate			ledical Exar	re .	W. Baltimore			1223				
Regis	rar	31. Date filed (Month, Day, Year, NOV 3 0 2	012 Jene	n B.	park	1							
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			Please	Type or Prin						_	le.
			For State Registrar	State of Ma	•	•	tment of F ficate of i		,	giene _{Reg. No.} 2	2 38553
			Decedent's Name (First, Middle, Las	t)					2. Date of De	ath	3. Time of Death
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- Marie	Examin		4a. Facility Name (If not institution, give	street and number)	. 1	4	b. City, Town, or	Location of Death)	4c. County o	
_			Franklin Squ		pital	5-d	f Under 1 Year	Jale If Under 24 Hrs.	8. Date of Bir		MOre
	Funeral Director		5. Social Security Number (6. Social Security Number 217–32–8305	ex M 2□F 7. Age	e (În yrs. last birt 77		Months Days	Hours Min.	10/20	av. Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	ъ		Usual Residence of Decedent						10/20/	1 1 2 3 2	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it is ited at a process.	į	10e. Street and Number 1728 Langley Road				10f. Zip Code 212	21		10g. Citizen of Wh. U.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa	s Decedent of H	ispanic Origin? (S	pecify Yes or No	- 14. Race	- American Indian,
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ylaı	wild by Menta arked atic e	10	John Calvert					Marie	Wentz		
Maryland	2 sho		19a. Informant's Name/Relationship (7		- 1	_				er, City or Town, S	
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Division of Vital Records,	r Attend er death rector: / by the fi	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, far . <i>(Specify)</i>	m, street	, factory, office		28f. Location (. City or To	Street and Number	r or Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate has been signed by the attending physicia To the thereal Director. After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but	Medical		ysician: To the best on liner: On the basis of and manner sta	examination and						nner as stated. nd due to the cause(s)
	To the vithin To the comple	Mec	29b. Signature and title of certifier	and manner sta			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
	1.0		tung	- Ho	spital13	7	Doo	744524		11/2-3	2112
	1 1/1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pri	nt)		,		

DHMH 17 Rev 1/2001

State Registrar

		A	AMEND 4C & 30 PER	Type or Prin	t in E	Black II	ndelibl	le Ini	k. Ensure	All Copie	s Are	e Legible) .		
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	Physicia	_	1. Decedent's Name (First, Middle, Las							2. Date of D Month	eath Da	ay Year		3. Time of Death	
	Medic Examin	al	4a. Facility Name (if not institution, give	Walter H. (street and number)	Cowar	n, Jr.	4b. City,	Town, or	Location of Dea		20	County of De		15:301	₩.
-	Examili		Medstar Good	Samaritan t	tosp		Bo	alti	more			SUSA.			
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	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then the marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip		3.0		10g. C	itizen of What	Country'	?	
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Maryland 21215-0036	should and M is mai	1	19a. Informant's Name/Relationship (· · · · · · · · · · · · · · · · · · ·	19b. Maili	ing Address	s (Street	and Number or F	Rural Route Numb			Zip Cod	e)	
	and 2 Health em 27 ther tr		Doris E. Cowan / Wife		20h P	204 lace of Disp		-	ne Avenue,	Baltimore,	_	1239 _ocation - City	or Town	State	
mor	age 1 ent of nt: If it		1 ☐ Burial 2 🗓 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		C	emetery, cre Chesape	matory or o	ther plac	i	0/23/2012	200.1	Beltsy			
Baltimore,	permit. Page 1 a Department of I Important: If its any Injury or of		21. Signature of Funeral Service Licen	see		2			ss of Facility	<u> </u>	1	Dellay	1110, 1	VID	
	207 2 2		Dorota Marshall 23a. Part 1. Enter the disease, or com	uste Cla						ervices, PO		413 Balti		MD 2120)3
	Physician/		shock, or heart failure. List only a Immediate Cause (Final	one cause on each line.	-	i. Do not em	-#: ·	,	ig, sacri as cara	go of respiratory t	211001,		In	terval Between nset and Death	
	Medical Examiner		disease or condition resulting in death)	a. Due to a as a	consequ	ence of):	mmy	<u>a</u>							
	Examine	ē	Sequentially list conditions,	b. Due to (or as a	consequ	ence of:							-		
	uted d ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events	530 10 (0. 25 2									- 1		
	e executed cian and curial-transit	I— I	resulting in death) Last	Due to (or as a	consequ	ence of):									
760	certificate be nding physici use as the bu	edic		d											
Box 68760	n certifi ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic	pregnan	су		- 1	23d. Date of			- 5
B 0	requires that the death certificate be been signed by the attending physicii should be detached for use as the bu	Be Completed by Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (s)					Month	Da	y Year	
P.O.	aw requires that the ias been signed by the 2 should be detach	y Ph	Part II. Other significant conditions	-						23e. Did	tobacco	use contribute	to the	ause of death?	~
	equires sen sign ould br	ted	Esuphageal can	cer, Diabet	es !	Mellit	ns, co	agu	lopathy	10] Yes 2	2 No 3 🗆		<u> </u>	
Records,	has be ge 2 sh	mple.	A fib, Preumo	nia, Sepsi	3 , a	noxic	encep	shalo	pathy	24a. Wa aut per	s an opsy formed?	prior f	o comp ?	findings availa letion of cause	ble of
Ä.	an: The tificate tor, pa	ပို	25. Was case referred to medical					26. P	lace of Death (C		s 2 2 1	No. 1 □ '	res 2	No	
of Vital	hysici his cer al direc	မ	examiner? 1 Yes 2 No	Hospital: 1 Inpatier					4 L Nursing	Home 5 ☐ Re			ecify)		
ı o	Attending Physician: r death. sctor: After this certific by the funeral director,	cate:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	of 2	28c. Injui wor 1 [28d. Describe	how inju	ıry occurred			
Division	r Atten er dea' rector: by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 280 Place of Injur			reet, factor	y, office			(Street a	nd Number or	Rural Ro	oute Number,	
2 5	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2.		20 Outil 1 Poutition Di	ysician: To the best of n			occurred o	t the tim	o data and place				stated		
>	n 24 hc	Medical	(Check 2 Medical Exam	niner: On the basis of expression of the basis of expression of the basis of the properties of the basis of t	amination	and/or inve	stigation, in	my opini	on, death occurre	ed at the time, date	and plac	e, and due to the	ne cause	(s) and manner : ed.	stated.
	with a second	_	29b. Signature and title of certifier	516/	M	D			e number			eate signed (Mo			
	1		30. Name and address of person who	completed cause of de				ر با			10	120/2	212		
			SHAHAB BABAKNOHI					BA1	LTIMORE	MD 21239)				
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar	r's Signat	ture	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month 24/20 2 Rebecca Gilbert Craig 8:45 A_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot. 10696 Chapel Road Cordova 5. Social Security Number 213 - 38 - 896 2 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 0 977 P7 19 14 98 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Talbot Cordova 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10696 Chapel Road U.S.A. 21625 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha Homemaker Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reese M. Gilbert Grace Cooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10696 Chapel Rd. Cordova, Maryland 21625 Renna Ambrose (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-01-2012 Important: It any injury or Aberdeen, Maryland (emetery 4 ☐ Donation 5 ☐ Other (Specify) estuan Zellman Funeral Home, Signati 23 S.Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition resulting in death) WEEKS Medical Due to (or as a consequence of): Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed burial-transit ATRIAL and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for L Month Pregnant at time of death the detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ þe The law requires 1 Yes 2 No 3 Probably 4 Unknown ALTERIAL OCCLUSIVE ONEMSE Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 No Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 CAND DAVE HTELS မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of : After t Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 171339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21658 125 UN OLINARIO HARMS SHAZUAY DRIVE MO 31. Date filed (Month, Day, Year) NOV 3 0 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2012 5:35 p M Virginia Mae Comer November Medical 4a. Facility Name (if not institution, give street and number) Apt. 139 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 128 West Ring Factory Road Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 219-20-7935 1 □ M 2 🔀 F 88 Nov. 23, 1924 North Carolina Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 128 W. Ring Factory Rd. Apt. 139 21014 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Alice Burcham Earl Ernest McIntyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Slusher / Sister 2235 Old Quaker Road, Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 11-29-12 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. Bel Air, Maryland dura of Funeral Service Light see McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myocardia Pnysician/ disease or condition Medical resulting in death) Examiner 7001 oronar Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events burial-trar and Due to (or as a consequence of): resulting in death) Last Physician/Medical the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be Pulmona Obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbf{X}\) Residence 6 \(\sum \) Other (Specify) 2 X No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 has filled in by the funeral After t s after death.

death with the Maryland

72 hours after

Maryland

Baltimore,

within 24 hours a To the Funeral I Medical completely State Registrar

determined

Certifying Nurse

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print)

MD 2014 Toll: gate Rd Bel Air, MD

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month. Day. 3 0 201

4 \square Homicide

29a. Certifier

(Check

29b. Signature ar

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 24, 2012 Allen Roberts Coale Medical 540 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs, last birthday) Funeral Days Hours Min. Jul 23, Ye November 24, 2012 1⁄917 Director 95 717-10-6474 1 X M 2 □ F Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20877 333 Russell Ave. #502 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–77 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Manager Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah Bechtold Howard Cronin Coale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11926 Frost Drive Bowie, MD 20720 19a. Informant's Name/Relationship (Type, Print) Charles H. Coale/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 11/28/12 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ malignomt disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner covonor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: cardiomvopath Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24a. Was an After this certificate has I funeral director, page 2: autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **№** No မှ in 24 hours are:
the Funeral Director: After this wantefely filled in by the funeral directors. 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time date and place and date and lines and the first date and da 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D69148

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Marticker matas. 31. Date filed (Month, Day, Year)

3. Time of Death

0220

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 No

Maryland

14. Race - American Indian, Black, White, etc.

Specify: White

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar

10110 molecular Drive, Suite 200, Rockville, Mansimel

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Departr Import any inji		21. Signature of Fur	neral Service Lice	He OH	/ MO1:	251 Be	Name and A	ome C	facility Crem Heck	atio	n Serv	ice . Cl	P.C arks	Box	784 e. MD	21029
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leath. Ior: After the fune	Certificate:	1 XNatural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not	(Month	, Day, Year)	injury	М	work?			28d. Describe I	now injui	ry occurr	ea		
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in 24 ho he Fune pletely f	Medical	(Check 2	Medical Exar	ysician: To the bes niner: On the basis irse Practitioner:	of examination	n and/or invest	igation, in my	opinion, o	death occ	curred at	the time, date a	and place	e, and du	e to the c	ause(s) and n	nanner stated.
To t		29b. Signature and	. //	when	ipc,	2110	29c. Li	cense nu	imber						, Day, Year) 7, 201	2
MI		30. Name and addre	ess of person who		of death (Item	23a) (Type, P		Roci	kvil	le.	MD 208	50				
Stat Registra	~	31. Date filed (Monti	h, Day, Year)		gistrar's Signat			1.00								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Scott David Dressel 5:45a ^M Medical 2012 Now 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6519 Fallston Road Elkridge Howard Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Months Davs Hours Director 214-98-2635 1 XM 2 ☐ F 46 Oct. 27, 1966 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard MD 1 🗆 Yes 2 🔀 No Elkridge 10e. Street and Number 5 10f. Zip Code 10q. Citizen of What Country? Funeral 23e 6519 Fallston Road 21075 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ö ۾ 1 Never Married 2 X Married the Medical Exami Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maryland State College (1-4 or 5+) Hygiene. Inspector Hwy Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David C. Dressel Patricia Wolfe 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda L. Dressel - Wife 6519 Fallston Road Elkridge, Maryland 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pege 1 a Department of H Importent: If ite eny Injury or ot 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk. 12/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. pale brow 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death neuro endocrine Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician Physician/Medical Box 68760 for use as the IF FEMALE: res, outcome of pregnancy

Live Birth 2

Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Voar 5 Other (specify) Day Pregnant at time of death signed by the ef P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, cete hes been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificete hes autoosy 1 Yes 2 No 2 N **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 70058779 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knoll North Dr. KASAMON 5450 140 Colimbia 31. Date filed (Month, Day, 32. Registrar's Signature State 3 0 2012 NOV Registrar

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3 U 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gerald Seymore Dayton November 2012 Medical :10 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Nursing Home Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 XM 2 D F Days Hours Min May 28, Months West Virginia Director 236-58-0958 1934 78 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppa 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 23a Funeral 1703 Shirley Ave. 21085 USA items , hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ò ğ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 X No Specify: "natural", White 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Steel Manufacturer Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Edward Dayton Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Sadie Esther Weese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen R. Dayton / Wife 1703 Shirley Ave., Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Memorial Gdn 11-27-2012 | Bel Air, Maryland Air gr tuy of Fur Service Lice ee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician gement disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a nunsequence of Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No the 9 I Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has page performed' 2 🗆 No Yes 2 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA → Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural injury 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director; completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 26/2012 DU026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu S. Sachdev, 322 East Cecil Ave., North East, MD 21901 31. Date filed (Month, Day, Year) 32. Registrar's Signature acke 3 6 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items! per doc 10g per fh g934 12-11-12 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Norwood , Theodore Dennis Jr. 3. Time of Death 2. Date of Death Physician/ 10 MA Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MI Chefel 7 Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 106-48-7301 1 🛛 M 2 🗆 F 88 10/13/1924 Liberia Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Howard Columbia 4 8 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5651 Sheerock Court 21045 USA Liberia items "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married and 2 should be filed within 72 hours after. Health and Mental Hygiene. tem 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify **Black** Completed 3 Widowed 4 Divorced 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Auditor General Republic of Liberia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Norwood T. Dennis, Sr Catherine Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude Dennis/Wife 5651 Sheerock Court Columbia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite Page 1 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 11/27/2012 | Ellicott City, MD Johns Cemetery permit. 21. Spoature of Funeral Service Lice see 22. Name and Address of Facility Marshall-March Funeral Home 4217 Ninth Street NW Washington, DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mones disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No this certificate Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifice filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2 No 1 Yes ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 -27. Manner Death 28a. Date of injury Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 FIDE TSADIK 5755 Cedar Lane Columbia, MD State acks Registrar

PO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 November 28. Doudoumopoulos 8:40 Alexander Nicholas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4701 Willard Avenue, #631 Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-48-9399 Director 1 X M 2 □ F Vrs 88 October 1, 1924 Greece Usual Residence of Decedent ir then "natural", or Items 23e or 28a-f show the Medical Examiner must be nutified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🄀 No Chevy Chase Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20815 United States 4701 Willard Avenue, #631 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 M Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Psychiatry Doctor permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other than any Injury or other traumatic event, Int. 2015. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zoe Karamitsou Nicholas Alexander Doudoumopoulos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4609 Waverly Avenue, Garrett Park, Maryland 20896 Nicholas A. Doudoumopoulos/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November Montgomery crematory or other place) 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State Bethesda, Maryland 30, 2012 4 ☐ Donation 5 ☐ Other (Specify) Crematoriúm, Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Pnysician/ Community Acquired Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Years Alzheimer's Dementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Day to for as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. signed by the attending physician and use as the burlal-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation, Hypertension, History of 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been slg ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Esophageal Cancer 24a. Was an After this certificate has performed? Yes 2 X No 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, is B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify, Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner 1 to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I only one title of certifig 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar 32 Registrar's Signatur

eun Mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Young, M.D.

MOA 3 0

31. Date filed (Month, Day, Year)

DC25992

//4530 Connecticut Avenue, Ste. 104, Washington, D.C. 20008

November 28, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cecelia T. DeCarlo 7:50 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20 Lambourne Road #316 Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 181-05-2359 Director 1 M 2 XF 94 Sept 22, 1918 Usual Residence of Decedent Pennsylvania 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 20 Lambourne Road #316 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ₩ Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 r of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Med (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Cannon Anna Gedritis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2812 York Manor Road; Phoenix, MD 21131 James P. DeCarlo son 20a. Method of Disposition 1 Durial 2 D Crem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page cremation 3 Removal from State permit. Page Department of Important: If any Injury or once, 4 Donation Other (Specify) Dulaney Valley Mem Gardens 12/8/2012 Timonium, MD 21. Signature of Funday Solvice Mo 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Physician/ Directe YRAMI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 \ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 1 No |2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 26534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 3 0 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:28 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center altimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 438-72-5574 Director 1 □ M 2 😾 F 10/05/1947 Louisiana I and 2 should be filed within remove and 2 should be filed within remove 3 should be filed within and Mental Hyglene.

I them 27 is marked other then "naturel", or items 23a or 28a-1 should be sh 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 346 Kearney Drive 21117 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 8 Yrs. Elementary/Secondary (0-12) NY Public Library Librarian Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Pete McKeever Etta Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genetta E. Jefferson (Dght 346 Kearney Dr. Owings Mills, MD 21117 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1
Department of importent: if it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donardon 5 Other (Specify) Crema Woodlawn Crematory 12/1/12 Bronx, New York 22. Name and Address of Facility
Joseph H. Brown, Jr. Funeral
2410 N. Fulton Ave. Balto., N Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failumediate Cause (Final Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Exam To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlei-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannes of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ☐ Accident 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certified pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar al

Year)

31. Date filed (Month

Greene St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Physician/ Year 2012 EISERIKE ΡМ 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Hours Months Days (Month, Day, Year 10-30-1913 Director 066-01-6088 99 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral hours after death with 15210 Elkridge Way #1j 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1941 1 X Yes 2 No 1 Never Married 2 Narried ð Baltimore, Maryland 21215-0036 1945 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Postal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental Fishers ၉ Sam Eiserike (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marsha Kudlick - Daughter 18505 Chancery Court, Olney, Maryland 20832 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-27-2012 Adelphi, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Di 5.168e. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death s been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autonsy death? 1 Yes 2 No Yes 2 N 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 V Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

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V.

JOSEPH-M.D. SO.W-EDMONSTON DR. SHITE-207-THOMAS .. NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIMIN

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11 Day 28 **Physician** 2012 8:20 AM Solomon Elvove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Montgomery Rockville Collingswood Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-28-1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 ☑ M 2 □ F 578-30-6703 Washington, DC 89 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show Is marked other than "natural", or items 12a or 12a-f show I aumatic event, I'm Medical Eventhan Tust be natified at 1 X Yes 2 No ND Director Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 9440 Newbridge Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. □Yes 2 No 1 □ Never Married 2 □ Married If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify: White 3 Midowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Government Computer Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elke Miller ဂ Elias Elvove traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any injury or other traun 3136 Pheasant Run, Ijamsville , Maryland 21754 David Elvove - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rockville, Maryland Parklawn Cemetery 12-3-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels 21. Signature of Funeral Service Licensee Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cff Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed burial-transit Due to (or as a consequence of): nding physician pe Physician/Medical as the b death certificate for use a IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy atte in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 □ No law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy certificate 2 ∏No 1 □Yes 2 □No 1 ☐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide

Box 68760 Ö ۵. of Vital Records, Division

Saltimore, Maryland 21215-0036

To the within 2

Ahmed 31. Date filed (Month, Day,

4 Homicide

(Check only one)

29b. Signature and tit

29a. Certifier

Medical

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed He5hmat, MD - 2401 Research Blvd. , MD He5hmat Registrars Signature

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Midwle, Last 2. Date of Death Physician/ Worth CA Medical acility Name (if not institution or Location of Death County of Death Examiner Contaomeru Tom 100 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Mir 1 🗆 M 2 🗓 F November 28, 1921 90 Maryland 215-18-2343 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Marvland Montgomery Rockville 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 1235 Potomac Valley Road items ; death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🎇 No If Yes, Give þ 1 Never Married 2 Married 9 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: and Mental Hygiene. is marked other than "natural", Specify: White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Secretary Be 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) ပ John Byron Strawbridge Alice Josephine Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Hartness Road, Statesville, North Carolina 28677 JoAnn Wamsley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Park Rockville, Maryland 30, 2012 4 Donation 5 Other (Specify) 21. Signature of Funer Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. hette Bonard Com 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ai disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No n signed by the a lid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown has been sig ye 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of anoi autopsy , page performe death? certificate I 2 No 1 Yes Yes Hospital or Attending Physician: ours after death.

neral Director. After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nos 0

DHMH 17 Rev 7/2009

State Registrar 32/ Registrar's Signatur

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Division of Vital Records,	ai or A s after i Direction b	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)												
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	To the within To the comple	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar st Signature											7	
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			30. Name and address of person who	completed cause of	death (Iter	n 23a) (Typ	e, Print) O B	sx 1	733	Salist	hur	4 140	2180	2
	Sta Registi		31. Date filed (Month, Day, Year) NOV 3 0 2012	Server 32. Regis	rar's Signa	gar	V							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No.? Decedent's Name (First, Middle, Last) 2. Date of Oeath 3. Time of Death Physician/ Month Ruth Freeman 11 15 2D12 3:28 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Oays (Month, Day, Year) Hours Min. 062-03-2603 1 🗆 M 2 🕅 F 9-22-1919 New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 6105 Montrose Road 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐X No If Yes, Give Year or Oates. 1 ☐ Yes 2 ☒ No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Mass Tillie Durschnitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Freeman - Daughter 261 Pope Street, San Francisco, California 94112 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Star of David @ Palm Beach 11-18-2012 West Palm Beach, Florida 21. Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 6 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy, performed? Yes 2 No 25. Was case referred to medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled n by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760

Division of Vital Records,

Funeral

Director

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or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

within 72 hours after death

I Hygiene, other than "

2 should be file h and Mental H ris marked ot

permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any Injury or other traumatic or

Physician/

Medical

other traumatic event,

Maryland 21215-0036

Baltimore,

Be မ

26. Place of Death (Check only one) examiner?
1 Yes Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 A Natural
2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗷 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05

State Registrar

31. Date filed (Month, Day, Year)

05 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Ferraro Physician/ 26,201 Noviember 6:13 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSDITAI baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Hours 060-40-8600 Director 1 X M 2 □ F 64 04/12/1948 Italy il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛱 No New York Pattersonville Schenectady 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 658 Sulphur Springs 12137 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Mechanical Elementary/Secondary (0-12) College (1-4 or 5+) General Superintendent Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of Anita Ceppellotti Edmondo Ferraro other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 658 Sulphur Springs Pattersonville, New York 12137 Fay Ferraro Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State MostHolyRedeemerCemetery 12/5/12 Niskayuna, New York 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, F.A. 21. Signature of Funeral Service Licenses michael 1 mars 6009 Harford Road Baltimore, Marland 21214 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ GLIOBLASTOMA MULTIFORME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or have within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page? 1 🗌 Yes 2 🗌 No 20 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဍ 1 Pinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MBBS 30. Name and address of person who completed cause of death (Item 23a) 20V DA VENKATA ANGIREKULA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death NOVEM DEC Physician/ 201 Medical 4a. Facility Name (if not institution, give stre Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min july 15,1936 163-32-1929 1 ₹M 2 □ F Pennsylvania **Director** 76 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Blair Pennsylvania Hollidaysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 212 Fees Lane 16648 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: r Yes, Give Year or Dates. 1967-69 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Medical Doctor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Juliana Connolly Archibald W. Fees, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or are 212 Fees Lane, Hollidaysburg, Pennsylvania Susan Fees Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 11-24-12 Carrollton, Pennsylvania St. Benedict Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 21214 6009 Harford Road, Baltimore, Maryland Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last inding physician a use as the burial-Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day for Month Year Pregnant at time of death the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No ER/Outpatient 3 DOA ဂ္ 1 Natient 2 -4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral dir 27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No (Month, Day, Year) 1 Natural 5 Pending injury within 24 hours after death. To the Funeral Director: At Investigation Accident 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Morroe MD tunc

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, FOF	Department of Health and N Certificate of Death	Mental Hygiene Reg. No. 2012 38574
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last) BARBARA J. FRANKOVIC		2. Date of Death Month Day Year Vear 4:43 P. M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 6000 GLENNOR ROAD	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death N/A
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/14/1949 9. Birthplace (State or Foreign Country) MARYLAND
Ī	and show l at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Maryli 28a-f	Director		TIMORE CITY	1 X Yes 2 □ No
	vith the 23a or st be r		10e. Street and Number 6000 GLENNOR ROAD	10f. Zip Code 21239	10g. Citizen of What Country? USA
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- 14. Race - American Indian,
21215-0036	iin 72 hours e. han "naturi e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) DFFICE MANAGER	ADVERTISING AGENCY
	ed with Hygien other tl	Be C	12TH GRADE 17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
Maryland	should be file h and Mental I 7 is marked o raumatic eve	욘	VICTOR FRANKOVIC	LOREN	E MOREHART
Man	2 shoul th and I th sm:			. Mailing Address (Street and Number or Rura BO2 CEDARBROOKE PLACE	ral Route Number, City or Town, State, Zip Code) E NOTTINGHAM, MD 21236
re, l	1 and 2 of Healt item 2 other		20a. Method of Disposition 20b. Place of		Date 20c. Location - City or Town, State
Baltimore,	t. Page tment or tant: If tjury or		4 Doyation 5 Other (Specify) METRO	CREMATORY, INC. 11/	30/2012 CATONSVILLE, MD
Ba	permil Depar Impor any in		21. Signature of Funeral Gervice Livensee MO1139	22. Name and Address of Facility OHN 8521 LOCH RAVEN BLV	NSON-FOSBRINK FUNERAL HOME, P.A VD. TOWSON, MD 21286
	Pnysician Medical Examiner	ner	231. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Melanoma	Approximate Interval Between Onset and Death
09	icate be executed g physician and is the burial-transit	dical Examiner	Cause. Enter. Underlying Cause (Disease or iinjury that initiated events resulting in death) Last c. Due to (or as a consequence of	νη: -	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
ds, P.O.	ruires that th an signed by uld be detac	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O.	: The law rec icate has bee r, page 2 sho	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1	26. Place of Death (Checutpatient 3 DOA Other: 4 Nursing Ho	ck only one) Home 5 Residence 6 □ Other (Specify)
Jo L	ling Ph .r After th funeral		1 Natural 5 ☐ Pending (Month, Day, Year) ir	Fime of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury occurred
Nision	after death birector: A In by the fi	Certificate;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
Δ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, (check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one) 4 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 5 Certifying Physician: To the best of my knowledge, only one) 6 Certifying Physician: To the best of my knowledge, only one) 6 Certifying Physician: To the best of my knowledge, only one) 7 Certifying Physician: To the best of my knowledge, only one) 7 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying Physician: To the best of my knowledge, only one 10 Certifying	or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated
_	To the within To the comple	-	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	tov		30. Name and address of person who completed cause of death (Item 23a) (11/29/12 15 Cotherle pp, 21053
	Sta		31. Date filed (Month, Day, Year) 0 2012 32. Legistrar's Signature 1.00 3 0 2012	bare	in controller
	Registr	ar	1904 O COLL COMPANY	//	

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			State of Maryland / Dep	partment of Health and N artificate of Death	Mental Hygiene	0010 00575		
			rogistal	2012 385/5				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death		
	Medic		Howard Marshall Fausold	4b. City, Town, or Location of Death	November 25			
	Examin	er	4a. Facility Name (if not institution, give street and number)	County of Death				
			10032 Renfrew Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Silver Spring If Under 1 Year Lift Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign		
	Funeral Director		253-64-8053 1 M 2 F 75 Yrs.	Months Days Hours Min.	(Month, Day, Year) 01/21/1937	Country) California		
			Usual Residence of Decedent		01/21/1997	CGIIIGENIG		
	short short dat	ģ	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits		
	Mary 28a-1 otifie	irec		Shannon		1 ☐ Yes 2 🗓 No		
	h the Saor ben	윤	10e. Street and Number	10f. Zip Code	ľ	zen of What Country?		
	th wit ns 23 must	Funeral Director	831 Lindenwood Drive	15234		S.A		
	r dear		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Race - American Indian, Black, White, etc.		
336	s afte al", c Exam	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛛 No Specify:	s	Specify: White		
Ŏ	hour natur fical	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kin	nd of Business Industry		
215	in 72 e. Mec	ᇤ	Elementary/Seconday (0-12) College (1-4 or 5+) life.	e kind of work done during most of work DO NOT use retired)	Aı	rmy Corps.		
7	ygien ygien her tl			vil Engineer		f Engineers		
Maryland 21215-0036	e filec ntal H ed otl even	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden St			
ž	uld b d Mer nark natic		Howard Marshall Fausold, Sr.	Elizabe		agor		
Ma	2 sho th and ?7 is 1	- 9		ling Address (Street and Number or Rur 6 Elmhurst Street,				
e,	and Heal tem (20a. Method of Disposition 20b. Place of Disp	osition (Name of		cation - City or Town, State		
<u>o</u> u	age 1 ent of nt: If i y or c			ematory or other place) ifts Registry 11/2		over, Maryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1		22. Name and Address of Facility Ar				
m	lmp any any	3	MAKE.	7522 Connelley Dr.	, Ste. P, Ha	nover, MD 21076		
Н			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between		
~	Physician		Immediate Cause (Final disease or condition Metastatic Panc	reatic Cancer		Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a consequence of):					
		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).					
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	ificate ig phy as the		IE CEMALE.		555 0			
ğ ×	eath certifica attending p	an/l	FEFMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy	2	23d. Date of delivery		
Box 687	death he ath	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		Month Day Year		
P.O.	at the d by t etach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?		
ω̈́.	requires that the der been signed by the s should be detached	Completed by	Pulmonary embolism		1 ☐ Yes 2 🖸	No 3 □ Probably 4 □ Unknown		
ğ	requi been shoulk	lete			24a. Was an	24b. Were autopsy findings available		
ecc	e has	d L			autopsy performed?	prior to completion of cause of death?		
E	an: The tifficat or, per	Be C	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 X No			
Vit:	I Physician: The lav r this certificate has aral director, page 2	To B	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	ome 5 🗆 Residence 6	Girlfriends X Other (Specify) Home		
o	ding Ph th. After thi funeral	ie:	27. Manner of Death 1 ☐ XNatural 5 ☐ Pending (Month, Day, Year) 28b. Time (Month, Day, Year) injury	of 28c. Injury at work?	28d. Describe how injury	occurred		
ion	· Attendir er death. ·ector: Af by the fu	iţica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				
Division of Vital Records,	I or Attendated after death Director:	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,		
	To the Hospita within 24 hours To the Funeral completed filled	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	it the time, date and place, a	and due to the cause(s) and manner stated.		
	To the Comp	2	29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)		
			and M Janullan	D35996	11,	/27/2012		
			30. Name and address of person who completed cause of death (Item 23a) (Type					
				y Blvd, #400, Whea	aton, MD 2090	02		
	Stat Registra		31. Date filed (Month, Day, Year) NOV 3 0 2012 32. Registrar's Signature	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartlands Senior Living Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 217 20 9015 1 **Q** M 2 □ F 86 8/6/1926 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked outher than "natural", or items 23a or 28a-f show ury or orher trainaitie event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3004 North Ridge Rd 21043 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Year or Dates 1946 - 48 Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) State of MD Classification Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Agnes (Goertz) Joseph B. Griesacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul B. Griesacker PA 16508 1203 W. 26th St. Erie 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Depertment of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Baltimore, MD Woodlawn Cemetery 12/3/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Craig Witzke Funeral Care 21. Signature of Funeral Service Licens Note M00751 9 Newburg Ave. Catonsville MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. END - Stage Cardion yopathi Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier nsky apabrel 10 DOUS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NS ROUPEL SEMD 25 35 SMITA N 5 2

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV30

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of Hertificate of L		and Me		giene leg. No.	012	385	77
			Decedent's Name (First, Middle	e, Last)						2. Date of Dea		V	3. Time of	Death
	Physici		H.D.	rman 60	riro					Month / /	Day	2012	5/10	AM
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)	16.6		4b. City, Town, or	Location of	of Death		4c. C	County of Death	1	
	Examin	er	a 1 L	OSPITAL BALTIA			Baltin	1012						
	Funeral		5. Social Security Number		ge (In yrs. las	st birthday)	If Under 1 Year	If Under		8. Date of Birth	Yearl	9. Birth	place (State o	r Foreign
	Funeral Director		251-62-3273	12□F	72	Yrs.	Months Days	Hours	Min.	(Month, Day		0	intry) SC	
	. /		Usual Residence of Decedent											
	ylan		10a. State 10b. County			Town or Lo							10d. Inside Ci 1 X Yes	
	Ma-1-8	Ş	MD NA		В	Balti	more							2010
	or 28	je [10e. Street and Number				10f. Zip Code					en of What Co	-	
	th wi	Funeral Director	1619 North B	entalou St	reet			1216				U.S.A		
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Ori	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	. 1	 Race - Amer Black, White 		
٥	afte or It	F	1 Never Married 2 Mar	If Yes Give	No		1 ☐ Yes 2Ã No	Specify:				Specify: B	lack	
9500-91212	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show olical Exactiver must be rotified at	d by	3 Widowed 4 Divorced	Year or Dates:							105 1/5-	d of Business/	ndunta.	
ፈ	72 h	ete	15. Deced e r (Specify only highe	nt's Education st grade completed)		16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation fu <i>ring m</i> os	t of workir	ig .		meric	-	dit
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	filed within 72 I Hygiene. othar than "nat	ပိ	17. Father's Name (First, Middle,					18. Mothe	er's Name	(First, Middle,				
Ĕ	m = 0 5	Be	James Bethea	2301)						Johns				
Ž	2 should be and Menta is marked aumatic ev	우	19a. Informant's Name/Relation:	shin (Type Print)	- 1	19b Maili	ng Address (Street a	and Numb	er or Rura	l Route Numbe	r. City or	Town, State, Z	Tip Code) 🤈 🕽	216
Maryland	7575		Bobbie Johns				North							Md
	1 al Hea and the		20a. Method of Disposition	Oll-procher			osition (Name of matory or other place		77-744	ate		ation - City or		
چ	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	Cer	metery, cre.	matory or other place norial P	e) ark	12/4	1/2012	Woo	ndlawn	, Md	
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Baltimore,	permit Pages Department of Importent: If it any injury or c	9	MANA I A	Constant of	M	Ma	2. Name and Address arch F/H 300 Waba	Wes	t	Balti	more	ьм.	21215	
		1 6	23a. Pag1. Enter the disease, of	r complications that cause	d the death.							, 110	Approximat	9
П			shock, or heart failure. Lis	t only one cause on each	line.		1	3,					Onset and	
Н	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	chenic		110771PATTY						44111	
ч	Examiner			Due to (or as	s a conseque		-1						E here	
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	ted	nln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<										
•	xecu al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a conseque	ence of):								
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89	ficate p phy is the													
	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75.4				2	3d. Date of del	,	
Box	death atte	cial	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant a			⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>					Month	Day	Year
Р. О.	the c by the achec	Jysl	9 Unknown	9□ Unknown										
	that	by P	Part II. Other significant condit	ions contributing to death	but not resul	ting in the u	underlying cause give	en in Part	l.	23e. Did t	obacco u	se contribute to	the cause of o	death?
g	quires n slgi ald be	D D	Pro	TITE SAN	621					10,	Yes 2	□No 3□Pr	obably 4	Unknown)
င္ပ	Attanding Physicien: The law requires that the death certifica r death, externing the death certifica ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed	`	, -						24a. Was		24b. Were at	topsy findings	available
Re	he law e has age 2 a	Щ								autor perfo	rmed?	death?	completion of a	ause or
Vital Records,	icien: Th certificate rector, pag	e C	25. Was case referred to medic	al				26. Plac	e of Death	Check onl		1 - 1 - 1 - 1 - 1	20.00	
>	sicie s cert firect	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ient 2□E	R/Outpatie	nt 3 DOA Oth	or		ne 5□ Resi		S □Other (Spe	cify)	
Division of	y Phys er this eral di	<u>-</u>	27. Manner of Death	28a. Date of In		28b. Time o		y at		28d. Describe I	how injury	y occurred		
<u></u>	nding ith. :: Afte	딅	1 XNatural 5 ☐ Pend 2 ☐ Accident inves	ing (Moriti, D tigation	ay roar,	Injury		Yes 2□]No					
VIS	Attair dea	ij	3 Suicide 6 Could 4 Homicide deter	minor 400. Flaue Ul II	njury - At hor etc. (Specify)	ne, farm, si	treet, factory, office			28f. Location (a			ural Route Nun	nber,
ā	el or s afte el Dir	Certification;	4 Nomicide	building, e	sto. (Dpoony)									
	To the Hospitel or Attending Physicien: The within 24 hours after death, To the Eunerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certify (Check only 2 Medice	ing Physicien: To the bes	t of my know	vledge, dea	th occurred at the tin	ne, date a	nd place,	and due to the	cause(s)	and manner as	s stated.	s)
	ha H in 24 ha Fi pletel	Medical	one)	and manner s	stated.	-11 WHO/OF II								•
	To t To t	Σ	29b. Signature and title of certif		MI		29c. Licens		- 15	,	29d. Dat	e signed (Mont	n, ∪ay, Year) A	
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	7 Chr	/	30. Name and address of perso	n who completed cause	death (Item		Print)	(5.		b 1		m.,./	1	
	0 /2		Lohn Mo.	TILLY ME	300	v W	AT BITTINIT	12/2/	et	BATINO	1	18/4/18	1	
	St		31. Date filed (Month Day, Yea	2012 32 Regis	trar's Signat	1º	all							
	Regist	rar	MOLO	COLL CONT	- /-	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 20/2 Estelle 6,00 DM Maude Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Frederick 511 Brunswick Street Brunswick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Dec 22, Months Days Hours 1920 Director 91 1 M 2 X F North Carolina 217-22-7309 permit. Pege 1 and 2 should be filled within 72 hours efter death with the Maryland Depertment of Health end Mentel Hygiene. Importent: If item 27 is merked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examination use the notited at 10d. Inside City Limits 10a, State 10h Count 10c. City, Town or Location Director Brunswick 1 X Yes 2 No MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21716 511 Brunswick Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Licensed Practical Nurse Healthcare Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Mary Etta Coats Lee Andrew Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Brunswick Street Brunswick, MD 21716 19a. Informant's Name/Relationship (Type, Print) Stanley W. Gunther/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 11/28/12 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Homes Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Pnysician/ una Medical resulting in death) Due to (or as a con equence of) Examiner ordio Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Due to (or as a nonsequence of) Exami • Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the ettending physician end letely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 Ho 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 27 Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hospi within 24 hou To the Funer completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S, MAIN St, #202 MT AIN. GAI MA 1502

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT LYNN GLENN, SR. NOV 6:38 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12631 Eastern Avenue Baltimore County Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours 105-07-0867 99 Director 1**X**X M 2 □ F July 18-1913 PA. Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director Maryland 1 Yes 2XXNo Baltimore Baltimore County ms 23a or r must be n 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 12631 Eastern Avenue 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 yrs Research Chemist 6 vrs Chemical Industry should be filed w and Mental Hygi is marked othe Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Glenn Sarah Elsie Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robert L. Glenn, Jr. (Son) 7920 Roxbury Dr. Glen Burnie, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla Bel Air Memorial 1 X Burial 2 Cremation 3 Removal from State 12-3-2012 Bel Air, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death INFARCTION Immediate Cause (Final Physician/ MYOCAMDIAL Acu disease or condition Medical resulting in death) Due to (or as a consequence of) DISTAST Examiner CORDNON ANTEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): use as the burial-transi Due to (or as a consequence of): attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year signed by the at Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPENTENSIVE CARDIOVASCULAR Division of Vital Records, 1 Tes 2 To 3 Probably 4 Unknown MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 Yes 25. Was case referred to edica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 1 Watural injury 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) M.D 20017148 11-29-12

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2012

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, h. D.

32. Registrar's Signature

HONFOND

BOUTO,

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 03.03 AM Gladden Nancv Lee 1.1 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MD GOOD SAMARITAN HUSPITAL BALTIMORE If Under 1 Year If Under 24 H 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Days Hours 1 🗆 M 2 🕞 🗜 215-40-9094 70 Sept.2,1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4032 Raymonn Ave. 21213 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Storage Manager Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rodie Williams Pearline Belamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Gladden 4032 Raymonn Ave. Balto, Md. (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dec. 6. 2012 Balto, Md. Cemetery 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licensee 1412 E. Preston St. Balto, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final (ardio myo path disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregriant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

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MD

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit, Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonse.

Baltimore, Maryland 21215-0036

death with the Maryland

Examine Physician/Medical Completed by Be |은 Certificate:

IF FEMALE:

examiner?

27. Manner of Death

Natural

2 Accident
3 Suicide

4 Homicide

USTIN

ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran

24 hours after death.

Funeral Director: After this certificate I etely filled in by the funeral director, pag

within 2 To the I

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 - Pending work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES 000

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

30. Name and address of person ed cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BALTIMORE

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ECHOUFFO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. .-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 130 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Pikesville Milford Manor If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ₩ M 2 □ F 90 Yrs Director 216-16-1485 05/20/1922 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evandrian must be notified at 1 ☐ Yes 2 XX No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Apt. 884 21061 Funeral 102 Crain Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: <u>გ</u> Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene." Important: if item 27 is marked other than "any injury or other traumatic event, it = 100ce. Elementary/Secondary (0-12) College (1-4or 5+) Advertising 6 Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Virginia Stapf ပ္ Joseph Gourley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) great 1445 McKenry Drive, Finksburg, MD niece Ms. Linda M. Crouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 12/03/2012 4 Donation 5 Dother (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. M01357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or seart failure. List only one cruse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a conse quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ue to (or as a conse wence of): Hospital or Attending Physician; The law requires that the death certificate be executed mer and Due to (or as a consequence of burial-Box 68760. attending physician for use as the buria ne in Condition Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 1 No Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 1 □Yes 2 □N 1 ☐Yes 2 ☐ NO Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Mann F 1 Seath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

3+1 VA

State Registrar (Month, Day,

30

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM 2012 260566 nyewho Medical 4a. Facility Name if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death timore Johns LOOKINS If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 261-28-6647 Months Hours Director 1 ▼M 2 □ F 89 7, Nov. 1923 Georgia Usual Residence of Decedent 28e-f shov within 72 hours efter deeth with the Meryland 10c. City, Town or Location 10d. Inside City Limits ?7 is merked other then "neture!", or items 23e or 28e-f sho treumetic avent, the Medical Examinar must be mutified at Directo MD Baltimore 1 Yes 2 No Parkton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 533 Montclair Court 21120 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) el Hygiane. United States Public College (1-4 or 5+) 5+ Elementary/Secondary (0-12) 12 Physician Health Service Be Pege 1 end 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) merked o ဂ္ဂ George W Gaffney Bertha Llovd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth wife Marion R. Gaffney 533 Montclair Court; Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 e
Department of F
Importent: if its
eny injury or ot 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 12/12/2012 Owings Mills, MD 21. Signature of Funeral Sorvice Lice 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the ettanding physicien end d be deteched for use es the buriel-trensi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical or Attanding Physicien: The law requires that the deeth certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed After this cartificeta hes baen so funeral director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s effer de... •rei Director: Atte 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospitel or A within 24 hours efter To the Funerel Direc completely filled in b City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, 3 Certifying Nurse Practitioner: To the best of my knowledge, death of (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jovember X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans St Baltimore Maryland toler 31. Date filed (Month, Day, Yes 32. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

NOV 3 0

State of Maryland / Department of Health and Mental Hygiene 38583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day at 2012 Physician/ Month Nancy Lee Gately 5:12 November Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Baltimore Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 215-56-2041 **Director** 1 1 M 2 1 TE Yrs 71 Aug. 2, 1941 Maryland r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **11**08 Cowpens 21286 USA Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Manital Status 14. Race - American Indian. 1 Never Married 2 X Married þ Máryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Geissler Mary Kreis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Gately/Husband Towson, 1108 Cowpens Avenue Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any injury or conce. 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 12/4/12 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility Ruck Towson Funeral Home. Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ardio Respirator disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) ateral Sclerosis Examir Hospital or Attending Physician: The law requires that the death certificate be executed myotrophic ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate I 1 Yes 2 No 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MF 31826 11-27-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7601 Osier Drive Towson maryland Linthicum 21204 31. Date filed (Month, Day, Year) 32. Registrur's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year 10:20AM november 26 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 2Ci Amary lanc Hece ave Herr oint If Mnder 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Jumber 7. Age (In yrs. last birthday) **Funeral** Months Days 213/0650 Director r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Parkville 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1313 Dalton Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 IX Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief Executive Officer Furniture 3 if Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Grigora Erma Carol Peacock Angelo Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Rochelle Drive, Fallston, MD 21234 <u> Monica Carol Wirth / Daughter</u> Page 1 and 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ó = 6 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 X Donation 5 Other (Specify) 11/29/2012 Anatomy Gifts Registry Hanover, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lice Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HEPATIC disease or condition resulting in death) Medical MENDEDOC Examiner CIORCINOMA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death isigned by the a Id be detached for □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by GASNO-ESSANDGENC Corres 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 2 0 မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify) . Manner of Death 1 Natural To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

M. D. VA Mary

32. Registrar's Signature

0020390

nd Heath Care

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Peter M. Hart Physician/ Month Year 11/6 6:45a [™] Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Kent Examiner** 4b. City, Town, or Location of Death 300 W. Water Street Chestertown 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 043-18-5216 Days 1**X**XM 2 □ F 93 **Director** Usual Residence of Decedent 10b. County Kent 10a. State 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Chestertown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 W. Water Street 21620 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married ¹XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Year or Dates. 42-45 injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Manufactures Representative Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred L. Anne Chase Department of Health and Important: If item 27 is m any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 W. Water Street, Chestertown MD 21620 Margaret Alice Hart/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Cremation Center of MD 11/9/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between METASTATIC PROSTATE CONCER Onsetand Peath Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death the 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 2 No Yes 2 N 1 Yes 25. Was case referred to ledical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 No Other: within 24 hours after death.

To the Funeral Director: After this c completed filled in by the funeral dir မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar Signature and

FATRICK 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

120

29d. Date signed (Month, Day, Year)

CHESTERTOUN MO 2/620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38586 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Junear Physician/ ast 6:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HOLD ma 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days UNK Months Hours Director 1 □ M 2 X F 04, 1963 Virginia Sep Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter deeth with the Maryland Directo or then "netural", or items 23e or 28e-f s the Medical Examiner must be notified 1 X Yes 2 ☐ No MD **Baltimore** HASH, CAROLYR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 W. Belvedere Ave. apt. 21215 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Delbert Lee Hash Dorothy Lee Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartment of Heelth ar Important: If Item 27 is eny injury or other treu once. Cathy McDonald /Sister 26 Steeple Ave. Red Lion, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Nov 28 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory Signature of Funeral Service Lice MC(585) 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final and Death Physician/ se or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of burial-trensil Hospital or Attanding Physicien: The lew requires that the death certificate be executed enà lei Due to (or as a consequence of) resulting in death) Last ettending physician for usa es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day ba detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate hes baen signated to page 2 should to Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate hes autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ဍ 1. Inpatient 2 ER/Outpatient 3 DOA funerel 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1- Natural 54 hours after daath.

Funerel Director: After bletely filled in by the fur 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma	aryland / Depa <i>Cer</i>	artment of He			iene eg. No. 2	112	38587
Phys	siciar	1/	1. Decedent's Name (First, Middle, Last)				Date of Dea Month		Year	3. Time of Death
M	ledica amine	al -	4a. Facility Name (if not institution, give street and number)	on	4b. City, Town, or L	ocation of Death		2.7	20 2 3 y of Death	0832AM
	amme		Bon Secours Hospit	al	Battim		ty	10.000	y or Boatii	
Fund			5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	
			Usual Residence of Decedent	76 Yrs.			12 25	35	<u> </u>	MD
ryland -f sho	ied at	ctor	10a. State 10b. County	10c. City, Town or Loc					10	d. Inside City Limits 1 X Yes 2 No
he Ma or 28a	e notif	Funeral Director	MD NA 10e. Street and Number	Baltin	10f. Zip Code			10g. Citizen of	What Countr	
with t	nst b	eral	2800 Windsor Ave		212	16		U.	S.A.	
death	iner m		11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - America ck, White, et	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show	Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ※☐ If Yes, Give Year or Dates.	No 1	☐ Yes 2 🔀 No	Specify:		Specif	y: Bla	ck
5-0 2 hour "natu	edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupat kind of work done du	tion uring most of work	ng	16b. Kind of I	Business/Indu	ustry
ithin 7	the M	Com	Elementary/Secondary (0-12) College (1-4 or 5 2 yrs	+)	onoTuseretired) nsed Pra	ctical	Nurse	Sina	i Hos	pital
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", o	event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I			
Ylan uld be fill I Mental narked o	natice	욘	Walter Baker			Bertha				
re, Maryla 1 and 2 should be if Health and Men	r traur	1	19a. Informant's Name/Relationship (Type, Print) Karen Huston-Daughter		g Address (Street ar. Donegal					
Jore, ge 1 and t of Hea If item			20a. Method of Disposition	20b. Place of Dispos			Date	20c. Location		
Limo Page Iment o	jury or		1 ☐ Burial ※ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro)	12/1	/2012	B <u>alti</u>	more,	Md
Baltimo permit. Page Department of Important. If	any in		21. Signature of Funeral Service Licensee	M2 43	Name and Form 300 Waba	of West sh Ave,	Balti	more,	Md 2	1215
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Exami	_		T i	D D M						
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ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and	e printi	ica	d							
6876 certificate nding ph	e as th		IF FEMALE:	,						
Box 6 death cer	tor use	Physician/Me	If the past 12 mores?	2 Fetal death 3 E	Ectopic pregnancy Other (specify)			1	ate of deliver	ry Day Year
the deapy the	ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown	·						
cords, P.O. law requires that the	be det	۾	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.				e cause of death?
rds require	plnoul	eted								ably 4 Anknown sy findings available
VITAI RECORDS, sician: The law requires certificate has been significate has been significant but the significant	3ge 2 s	Completed					24a. Was a autop perfor	sy megt?	prior to com death?	pletion of cause of
an: T	director, pa		25. Was case referred to medical examiner?		26. Plac	ce of Death (Chec		2 L No	1 Yes 2	2 ⊔ No
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DIVISION OF tal or Attending PI s after death. al Director: After th	e tuner	Certificate	1 Natural 5 Pending (Month, Day 2 Accident Investigation		28c. Injury work? M 1 \(\sup \)		28d. Describe h	w injury occu	rrea	
IVISIO l or Atten after deat Director:	pò th	ertifi	3 Suicide 6 Could not be	iry - At home, farm, stre	eet, factory, office		28f. Location (S City or Town		ber or Rural f	Route Number,
DIVIS	illed ir									
To the Hospital or A within 24 hours after To the Funeral Direct	completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Wertifying Physician: To the best of 2 Medical Examiner: On the basis of e	xamination and/or invest	igation, in my opinion	n, death occurred a	the time, date ar	d place, and d	ue to the caus	se(s) and manner stated.
To th Withir	comp		29b. Signature and title of certifier	Affending	29c. License	number		29d. Date sign		
10 M	1		30. Name and address of person who completed cause of d	eath (Item 23a) (Type P	Print) D	16351 2000 321+1, 1	<u> </u>	11/2	4/12	<u></u>
0/)		Sherron Benn-Thou	up son,	u. D. E	Balti, 1	ND	T *		
Po-	State	_	31. Date filed (Month, Day, Year) NOV 3 0 2012	ar's Signature	Mal					
DHMH 17 Be	gistra		TOTO O LOTE COMME	1-17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Juanita Durman Homer 22, 2012 7:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Churchville Harford 8 Woodside Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 216-16-2638
Usual Residence of Deced 1 M 2 T 89 1923 21, Maryland rai", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Woodside Drive 21028 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black White etc. ۾ 1 Never Married 2 Married Pege 1 and 2 should be filed within 72 hours efter ment of Heelth end Mental Hyglene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiliary or other traumatic event, the Medical Examiliary. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed Specify: 3 Nidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Editorial Supervisor U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Harvey Durman Sarah Margaret Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra L. Shue / Daughter 10 Woodside Drive, Churchville, Maryland 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If any injury or once. 4 Conation 5 Other (Specify) Bel Air Memorial Gdn | 11-28-2012 | Bel Air, Maryland f Funera Service Lizense 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one calls on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the Innerial Innerial present page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🛱 Residence 6 🗆 Other (Specify) 2 🗆 No |၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number who completed gauge of de

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 27, 20°T2 Marie Harding Hannah 10:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8813 Goshen Mill Court Gaithersburg If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Feb 2, 1934 Maryland Director 1 M 2 XF 78 214-30-1468 ar than "neturel", or iteme 23a or 28e-f shov the Medical Examinar must be notified at 10d. Inside City Limits death with the Meryland 10a. State 10b. County 10c. City, Town or Location Director Frederick Monrovia MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21770 4196 Windy Hill Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give e filed within 72 hours efter de ital Hyglene. ed other than "neturel", or it Black White etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: if item 27 is marked oft eny injury or other treumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Deborah Harding Albert Vernon Harding 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 3950 Ramsey Drive Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) Vicky Tallerico/daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Final Journey Crematory 11/29/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 months Immediate Cause (Final Physician/ disease or condition Metastatic Non Small Cell Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sicien end e buriel-transit The lew requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last attending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months?
1 Yes 2 No Month Day Year signed by the at d be detached fo 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been siç r, page 2 should t 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclen: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) son's 2X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDO60335 28,2012 MD November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Bannen, M.D. 18111 Prince Philip Dr. #327 Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NOV 3 0 2012 Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Mo

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MADGE A. HUBBARD NOVEMBER 2012 11:00P^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTO. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 216-14-4083 1 🗆 M 2 🟋 91 Yrs 11-7-1921 MARYLAND 27 is mariled other than "natural", or items 23a or 28e-f show treumatic event, <u>the Medical Examilian matter</u> matter 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD. BALTO. **PARKVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 WALTHER BLVD. APT. 4327 21234 USA Pege 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12TH **BOOKKEEPER** DAIRY Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EDWARD P. APPEL SARAH A. GEISLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 WALTHER BLVD. #2405 PARKVILLE, MD.21234 pernit. Pege 1 end 2
Department of Health
Importent: If Item 2:
any Injury or other t <u>JUDITH KIMBALL</u> DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 11-29,2012 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a nonsequence off To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2 X No Be Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: To 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner accurred. (Check 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORGAN. 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 3 U 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11:40 p.m.

NOVEMBER

MADGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ arlene NO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Center Baltimore City Baltmore Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) Country) Maryland **Director** 214-62-1333 60 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Kent Co. Chestertown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 206 Hilltop Lane 21620 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Assistant Anne Arundel Co. Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked ott any injury or other traumatic even! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sally Maynard Gouldin Fenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Stevens / Son Mr. Timothy 101 Avenue D, Apt 11C New York, NY 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Glen Haven Mem. Park | 12/03/2012 | Glen Burnie, MD 21. Signature of Funeral Secretaria 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pfrynician/ Trai disease or condition resulting in death) Medical Due to (or as a c is quence of) Examiner 5 monm Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as consequence of) Examir sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 P No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy performe death? 2 🗋 No Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to d in by the funera 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

Mercy medical

32. Registrar's Signature

St Paul St BaltimorchD 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christina Chaoman.

NOV 3 0 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend If em 19b per fn g933 11-30-12 vt State of Maryland / Department of Health and Mental Hygiene

	State of Mari	Certificate	of Death	Reg. N	2012	3859		
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Physician /Medical	SHIRLEY	HOFFMAN		Vovember	128 201	21:00 a		
Examiner	4a Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		c. County of Death			
	COURTLAND GARDENS	In was last hirthday) If Under 1	PIKESVILI Year If Under 24 Hrs.		BALTIMOI			
uneral irector	5. Social Security Number 216-28-8924 Sex 1 □ M 2 □ F 7. Age (I		Days Hours Min.	8. Date of Birth (Month, Day, Year 11/22/19	7) 28	place (State or Forei intry) MD		
tel Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director		Oc. City, Town or Location				10d. fnside City Limit		
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or 28a-f	10e. Street and Number	10f. Zip C	ode	10g. C	itizen of What Cou	intry?		
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iner iner	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U,S. 13. Was Decede If Yes, specif	nt of Hispanic Origin? (Spec y Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ameri Btack, White			
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7 is marked other traumatic event, I To Be Co	19a. Informant's Name/Relationship (Type, Print)		IDA Street and Number or Rural	Route Number, City)BERG ip Code)		
F #	ALISA OSTROW/DAUGHTER		EST RUSH ROA			2111/		
other of	20a. Method of Disposition	20b. Place of Disposition (Name cemetery, crematory or oth	of	Date 20c.	Location - City or T	Town, State		
important: if Item 2 any Injury or other DDCs.	1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	OHEB SHALOM MEMORIAL PAR	z 11	1/29/12	REISTERS	TOWN. MD		
injur B	21. Signature of Funeral Service Licensee			L LEVINSON				
E E G		8900	REISTERSTOWN					
	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each fine.				,	Approximate Interval Between		
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cate hes been signed, page 2 should be d				24a. Was an au performed?	a	Vere autopsy findin vailable prior to completion of cause		
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din d	4 ☐ Homicide determined building, etc. ((Specify)		City or Town, Sta	3 (Θ)			
Completely filled in by the f	29a. Certifier (Check only one) 1 Certifying Physician: To the best of n 2 Medical Examinar: On the basis of example and manner state.	camination and/or investigation,	the time, date and place, a n my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)		
omplo Me	29b. Signature and title of certifier	29c.	License number		Date signed (Mont)			
⊢ ō			2108614	No	ventur	-28, 201		
	30. Name and address of person who completed cause of deal	th (Item 23a) (Type, Print)	0, 1	.1	- 11801	1		
V		920 Scotts Les	2108614 vel Rd. Bul	timore.	Marylan	ne 21208		
State	31. Data filed (Month, Day, Year) 32. egistrar's	s Signatura						
Registrar	NOV 3 0 2012 Strang	A. barker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:00a 2012 November Irene M. Ingram 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care
5. Social Security Number Baltimore Towson Ruxton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 216-16-8831 88 1 □ M 2 ☐ F March 29,1924 Maryland 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State Middle River 1 Yes 2 No Md. Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21220 7321 Chesapeake Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2x ☐ No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BCDS Cafeteria Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Paul Brannock S1acum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7204 Greenbank Road Middle River, Md. 21220 Ron Jordan son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2012 Baltimore, Md. Cedar Hill 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licensee takanu 6224 Eastern Avenue Baltimore, Md. 21224

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical

Baltimore, Maryland 21215-0036

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	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final		1	2.1	or respiratory arrest,		Approximate Interval Between Onset and Death			
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au/	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta	I death 3 🔲 Ectopi			23d. Date of de Month	elivery Day Year			
ysic	1 Yes 2 No	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)								
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ţe:	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how inj					
fica	2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	М	1 ☐ Yes 2 ☐ No						
eri	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	and Number or Ru te)	ural Route Number,							
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Medical Certificate: To Be Completed by Physician/Medical Examiner	(Check 2 Medical Examine	cian: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or investigation,	in my opinion, death occurred a	at the time, date and pla	ce, and due to the	cause(s) and manner stated.			
Σ	29b. Signature and the of certifier	Tractationer. To the best of the	1	9c. License number	29d. [Date signed (Mon	th, Day, Year)			
	> Allan (Som	ma physi	ciam	D-14957	1	1-28-13	2			
	30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Print)	ford Rd. Bal	timore in	id, 2123	34			

State Registrar

32. R

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manuel Sonny James, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roseda Pita more 74ase If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, 068-58-0450 Director 1 🛛 M 2 🗆 F 40 11/06/1972 New York Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1X Yes 2 ☐ No New York Kings Brooklyn 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? Funeral 901 Drew Street, Apt. 11208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Non-Profit: Charity Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yvonne Renee Williams Manuel Sonny James, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Renee Williams/Mother 901 Drew Street, Apt.5, Brooklyn, New York 11208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State □XBurial 2 □ Cremation 3 □ Removal from State 12/08/2012 CypressHillsCemetery 4 Donation 5 Other (Specify) Brooklyn, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. I, Baltimore, Maryland 21214 nichael margullo 6009 Harford Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) rointest Medical Due to (or as a consequence of): Examiner Sequentially list conditions To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury 10 Ce that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical erem Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 MN 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) alle M.D 24/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 tuar Franklin Baltimore 31. Date filed (Month, Day, Year) State 30 Registrar

1 - For State Registrar

Physicia Medic		1. Decedent's Name (First, Middle, Last) HOMER LEO JONE:	S				2. Date of De Month	ath 26 ^{Day}	y 2012	3. Time of Death 4 * 37A M
Examir		4a. Facility Name (if not institution, give street and number) HOWARD COUNTY OF ALL	4b. City, Town, or Location of Death				4c.	4c. County of Death		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 12 F 73	oirthday) Yrs.	If Under 1 Year Months Days		*	8. Date of Bir (Month, Da Nov 20	y, Year)	Cour	place (State or Foreign htry) 1nois
faryland Ba-f show tified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Howard Jes	own or Loc	cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 8309 Barkwood Court	sup	10f. Zip Code 20794					izen of What Cou	ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ◯ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1962 If Yes, Give Year or Dates, -1965.)	If	Vas Decedent of F Yes, specify Cub	lispanic Origi an, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		S.A. 14. Race - Americ Black, White, Specify: White	etc.
within 72 hour giene. er than "natu , the Medical	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	lent's Usual Occup kind of work done O NOT use retired, Equipme	during most (ind of Business In	
The filed Hyarked oth	To Be	17. Father's Name (First, Middle, Last) Homer Reeves Jones			18. Mother	r's Name	<i>(First, Middl</i> e, garet S	Maiden S	Surname)	
12 should alth and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Kenneth A. Jones / son		g Address (Street					Town, State, Zip	•
Page 1 and ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place ceme	of Dispos tery, crem	sition (Name of natory or other pla matory	ce)	D	ate 9/2012	20c. Lo	ocation - City or To	own, State
permit. Departrimporta		21. Signature of Funoral Service Licensee / M00770	22 D	Name and Addre onaldson 13 Talbo	ss of Facility Funer	al E	Iome, P	.A.		20707
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition								Approximate Interval Between Onset and Death
Medical Examiner	اد	resulting in death) Due to (or as a consequence CAPD1 Sequentially list conditions,	AC	APF	LES"	T				
xecuted n and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequenc C. Due to (or as a consequenc)	EIN	VTH	RoM	Bo	515			
ath certificate be executed attending physician and for use as the burial-transit	cian/Medical	d								
ne death certifi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 2 ☐ Pregnant at time of death 3 ☐ Unknown 3 ☐	ath 3 🗌	Ectopic pregnan Other (specify)	су			4	23d. Date of deliv Month	ery Day Year
uires that the nices	by	Part II. Other significant conditions contributing to death but not resultin	g in the ur	nderlying cause gi	ven in Part I.					ne cause of death?
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	Completed						24a. Was autop perfo 1 Yes	rmed?	prior to co death?	psy findings available mpletion of cause of
sician: certifii	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	0.11!1	Oth	lace of Death er:				П	
inding Phy ath. r: After this ie funeral o	Certificate; T	27. Manner of Death 1. Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	. Time of injury	28c. Injur worl	y at	2	8d. Describe h		Other (Specify occurred)
tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		2	8f. Location (S City or Tow		d Number or Rura	Route Number,
the Hospi nin 24 hou the Funer	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of examination and only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge	/or investi	gation, in my opini	on, death occ	curred at t	he time, date a	nd place,	and due to the ca	use(s) and manner state
		29b. Signature and title of certifier As I Addow a		29c. Licens	e number	765		29d. Date	e signed (<i>Month</i> ,)	Day, Year)
lohu		30. Name and address of person who completed cause of death (Item 23a Abdul Arrifuddowia 5755 ((Type, Pr	Lane	Col	uml	Dia, M	D	21044	-
Stat Registra		Abdul Arrifuddowia 5755 (31. Date filed (Month, Day, Year) NOV 3 0 2012 (September 1)	pa	Med				_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jadeson. Physician/ Year Month 8.551 James 11 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Manor Care Rossville Rossville Baltimore 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 XM 2 ☐ F Months Days Hours Min Year **Director** 113-14-0534 87 1925 New York Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 3001 St. Clair Drive Apt. 118 21009 USA items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify. 3 Widowed 4 Divorced Completed Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Transportation Truck Driver and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence (unk) Jackson Carrie (nmn) Rhem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau Lula V. Jackson / Spouse 3001 St. Clair Drive, Apt. 118, Abingdon, MD 21009 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11-27-2012 Fallston, Maryland Highview Mem. Gdn Signatur of Fune Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chrone Kionie disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Stemoor Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate or Attending Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) upleted filled in by the funeral 27. Manner of Beath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Matural work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the Hospital State Registrar

Medical

29a. Certifier

29b. Signature and title of certification

31. Date filed (Month, Day, Year)

NOV 3 0 2012

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHDAIR A- HARHMI MD, 821 N. ENTAW ST EME 305 BALTIMOREMID

MID

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

03146

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27, 2012 November 10:00 AM Johnson Edith Mary Crews Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral OCT 17, Year) 933 North Carolina Director 579-48-1498 1 □ M 2 💢 F 79 Usual Residence of Dece 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminer must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20817 6505 Winnepeg Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: If Yes. Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Bank/Financial 12 Safe Deposit Box Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Edward Crews Ann Elizabeth Nutt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408–A Brock Bridge Rd. Laurel, MD 20724 Nancy E. Risinger/daughter Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/30/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licen-Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Liver Cirrhosis Sequentially list conditions, Examine if any, leading to immediate cause. Finter Underlying Due to (or as a consequence of) sician end burial-transit Cause (Disease or injury that initiated events requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 5 Other (specify) page 2 should be detached Yes 2 √No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law autopsy performed certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ₺ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending Division 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of celtifie 29d. Date signed (Month, Day, Year) ilvara Viete 11/27/2012 1)0068405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

NOV 3 0 2012

32. Registrar Signatu

Jesus David Guevara-Nieto, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year JAFFEL 2 CORGE 4M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3 5+ BaltimurE AARLES H /401 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 126-26-5388 79 1 X M 2 □ F 05/27/1933 NY permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show eny highry or other treumetic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PALM BEACH BOCA RATON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22840 LA CORNICHE WAY 33433 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DEVELOPER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JAFFEE MOLLIE SHAPIRO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN JAFFEE / WIFE 22840 LA CORNICHE WAY BOCA RATON, FL 33433 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) BETH MOSES CEMETERY : 11/30/2012 PINELAWN, NY Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ D SICTING disease or condition resulting in death) TURTIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physician end for use es the buriel-transit The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the et Id be deteched fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, CARDIUMY OPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I ATRIAL FIRRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, pege 2 s 1 Yes 2 No ☐ Yes 2 🔯 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Sc MD restdence ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work?
1 Yes 2 No Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number NOVEMBER 28, 2012 D46387 20V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH COFRANCESCO, JR., M.D., 601 N. CAROLINE ST, JHOC, BALTIMORE, MD 21287 31. Date filed (Month, Day, Year) Registrar's Signat State

DHMH 17 Rev 06-2011

Registrar

NOV 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:58 PM Helen James John 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medica Center 106501 eph If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Year) an. 12, 1930 New York Director 577**-**70**-**7773 82 1 🗆 M 2 🔀 F 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6806 Bellona Avenue 21212 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married δ 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Professor of Philosophy Trinity University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk tment of Health and Mental rtant: If item 27 is marked o ည James E. John Helen G. McAlear Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. AgnesR. McNally (Friend) 305 Cable Street Baltimore, Maryland 21210 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12/29/12 Towson Maryland permit. 21. Signature of Funeral Service/Light 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. east 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCIZUT P disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ After this certificate has been signed by the atter funeral director, page 2 should be detached for in the past 12 months? Month Pregnant at time of death Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 Osler Drive Towson Maryland 21204 James M. Williams D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 NOV 3 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D Physician/ November George Earl Kelley 2012 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 12514 Jarretsville Pike Phoenix Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, Year) 190-28-1923 Director 1 🛛 M 2 🗆 F Sept. 26,1931 Pennsylvania 81 Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f sho Director Maryland Baltimore Phoenix 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12514 Jarretsville Pike 21131 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Specify: 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" any Injury or other treumetic event, the Medical Expone. Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) home products Elementary/Secondary (0-12) College (1-4 or 5+) manufacturing Director of sales and service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine DeBarber Earl Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12514 Jarretsville Pike Barbara Kelley/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 3,2012 Metro Crematory Baltimore, Maryland 21. Signature of Feneral Service Licenses Michell-Wiedereld Funeral Home, Baltimore, 6500 York Rd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on: Hospital or Attending Physicien: The lew requires thet the death certificete be executed After this certificate has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 L q 1 linknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 📝 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed

23a) (Type, Print)

cause of death (Ite

29c. License number

SUITE 101

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8 20 PM Samuel Brown Kyle 2012 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital FRANKLIN Sauare Rosedal Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 63 212 56 9883 Director 1 № M 2 🗆 F Sept. 18, 1949 Maryland 28a-f shov 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b Count 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modesil Examiner must be routhed at Director Maryland Baltimore Middle River 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7216 Greenbank Rd. 21220 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Trackman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Bernard Kyle Page 1 and 2 should be Russie Margaret Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Charles Edwin Kyle (Brother) 11501 Deadwood Drive Lusby, Maryland 20657 Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any Injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 12/5/2012 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 onm Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACECEBRAL Prysician/ HemoRRhage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PerTension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (ur as a consequence of) certificate has been signed by the attending physician and lirector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RESODOO 11-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto md mehmood 31. Date filed (Month, Day, Year) NOV 3 0 2012

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death Joseph Kelly Physician/ Month 2:35А м 11/26 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 218-09-5463 **Director** 1 🗷 M 2 🗆 F 94 2/13/1918 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Modical Examiner mastice in the dist 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2829 Guilford Avenue 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 ☐ Divorced Completed Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, Maryland 21 12 Newspaper Writer Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Kelly Mary Louise Bosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2616 St. Paul Street, BAltimore MD 21218 Jacques S. Kelly / Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If Ite any injury or ot 1 🗌 Burial 2 🛱 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Cremation Center of Mp 11/27/12 Hanover Maryland 21. Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 21230 Jiw 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ADENOCARCINOMA DUODENAL Medical Due to (or as a consequence of): Examiner METASTATIC LIVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed for use es the burlal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🔲 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director, **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check To the Vithin 2 3 🛛 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year Koreck RIARET 26 2012 ovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kr Itmone MerXTAR HARBUR HOED tol If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 212-20-2326 Days (Month, Day, Year) Hours Min Director 1 M 2 XF 88 12/11/23 MD Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1X Yes 2 No 10e. Street and Number 1417 E. Clement Street 10g. Citizen of What Country 10f. Zip Code Funeral 21230 UŚA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဍ Peter Blinkey Fewronia Husak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 E. Clement Street, Baltimore MD 21230 Donna M. Berger / Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cremation Center of MD 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State 11/29/2012 Hanover Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. DUC S 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANdine Annithmin disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed YARS CORNARY ANTERY DISEA the attending physician and thed for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Breast rancer 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? HTPERC. P. Jem! A 24a. Was an After this certificate has autopsy 1 Yes 2 🗆 No filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1-Natural 5 Pending 24 hours after death. Funeral Director: Al 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061438 ·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South MAROVER St BAltimone MD 21225 ANDREW 1KOV!12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 33605 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:59 P.M Jean Ann Kopp November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4206 Main St. Carroll Lineboro If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral Director** 220-46-8061 1 □ M 2XXF 84 Jan. 30, 1928 PA Usual Residence of Decedent show at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f XX Yes 2 No MD Carroll Lineboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 23a Completed by Funeral death with 21102 U.S.A. 4206 Main St. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give 3XXWidowed 4 ☐ Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clara Harner John Yealey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 Main St., Lineboro, MD 21102 Phillip L. Kopp (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Office (Specify) 12/4/2012 Hanover, PA Mt. Olivet Cemetery 21. Signature of Funeral Salva Udensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., MD 21102 Manchester, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death g Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Pay, Year) 0061206

State Registrar 30. Name and address of person who completed

0 2012

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 06-2011

Westminster

em 23a) (Type, Print

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07:15 A M Medical flity Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth Month, Day, Yea DEC 14, 1 7. Kee (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Director 107-36-7548 70 14, 1 XM 2 🗆 F Germany or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Suffern 1 XYes 2 No Rockland NY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10901 USA 10 Sterling Forest Lane permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any lipiny or other traumatic event, the Medical Formitter and pines. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces?
1 ♣Yes 2 □ No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 ri res, Give Year or Dates. 1964–66 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Financial 4 Operations Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hildegrad Krobisch Otto Pöhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Sterling Forest Lane Suffern, NY 10901 Pirita Krobisch/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 11/30/12 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician esophageal cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated exacts.) Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year signed by the at Id be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cooribute to the cause of death? 2 Records, been sign Completed 2 VNo 3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy 2 🗓 1 Yes 2 No ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury 5 Pending ours after death.

neral Director: Af

filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Michael R.a November 29 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Michael R. Grunwald

31. Date filed (Month, Day, Year)

NOA 3

1800 Onteans Street

32. Registrar's Signature

Boltimore ManyLand 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Emmette L		1- For State	State of Maryla		rtment of		d Mental H			112 3360
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, I Jerry E.	Middle,Last) Lewis, Jr.					2. Date of Deat Month November	Day Year	3. Time of Death 1042 hrs
		4a. Facility Name (if not inst 208 Luguain Court	stitution, give street and number) urt			4b. City, Town, or Location of Death Baltimore		<u> </u>		
Funeral Director		5. Social Security Number 428–37–9481	6. Sex	7. Age (In yrs. Ia 48	st birthday) Yrs	If Under 1 Year Months Days	+	_		Birthplace (State or Foreign Country) MS
and f show any nice.	ō	Usual Residence of Decedent 10a. State		10c. City,	Town or Locati		ikesville			10d. Inside City Limits 1 Yes 2 X No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 708 Lugua:	in Ct			10f. Zip Code	21218	10	g. Citizen of Wha	at Country? USA
after d	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 15. Decedent's Education	Married Armed For 1 Yes Divorced If Yes, Give Yee or Dates:	² No 85-07	1	s Decedent of His es, specify Cuban Yes 2 X No It's Usual Occupati	specify:	Rican, etc.)	14. Race - White, Specify: 16b. Kind of Bus	Black
Baltimore, MD 21215-0036 bemit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam	Completed	Elementary/Secondary (0	O-12) College (1		during m	ost of working life. Opter Me	DONOT use ret chanic	tired)	US Mil	·
21215-C wld be filed v Mental Hygi marked oth c event, be	To Be Co	17. Father's Name (First, Mi Jerry E. Lev 19a. Informant's Name/Rela	wis, Sr.		19b Mailine	g Address (Street	Mildr	e (First, Middle, Noted Donal	ldson	State 7in Code)
and 2 shou feath and I tem 27 is it	ř	Milds 20a. Method of Disposition	red Lewis /M	20b. P	277	3 Airpor	t Road,	Newton	MS 39	345 City or Town, State
Baltimore, permit. Pages l an Department of Her important: If ite		1 Burial 2 Crem 4 Donation 5 Othe 21. Signatuce of Funeral Se	nation 3 X Removal from the Removal from			is Mem. C		1/17/12	Newton	
Physician Physician	4	23a. Part I. Enter the diseas	86	>	[15	lame and Address aries L. 01 E. For	rt Avenu	ie. Bait:	more MD	21230
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardioavascular Disease Due to (or as a consequence of):								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulti								
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Box 68760, he death certificate be the attending physic ned for use as the burned for us	\$	IF FEMALE: 23b. Was decedent pregnampast 12 months? 1 Yes 2 No 9	t in the 23c. If yes, of 1 Live b	outcome of pregnirth	ancy 2 Fe	tal death 3 [Ectopic pregna		23d. Date of o	lelivery Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed by Ph	Part II. Other significant co	onditions contributing to						2 No 3 no 3 no 3 no 3 no 3 no 3 no 3 no 3	probably 4 Unknown Probably 4 Unknown ere autopsy findings available ior to completion of cause of path?
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n of Vil ding Physic After this funeral dire	on: To	1 ✓ Yes 2 No 27. Manner of Death 1 ※ Natural 5	28a. Date (Month,		ER/Outpatient 28b. Time of I	njury 28c. Injur	y at Work?		Residence 6 🗹	_
Division of To the Hospital or Attending Physical A hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	2 Accident 3 Suicide 6	Pending Investigation Could not be determined (Specify)	e of Injury - At ho	me, farm, stree	et, factory, office be	es 2 No	28f. Location (S or Town, St		r or Rural Route Number, City
o the Hospi ithin 24 hou o the Funer	Medical Co	29a. Certifier (Check only) Certifyli	ng Physician: To the bes Examiner: On the basis of and manner si	of examination an						
H 3 H 3	×	29b. Signature and title of co				29c. License O.C.M			29d. Date signed November 6	d (Month, Day, Year) 5, 2012
V		30. Name and address of pe Ana Rubio M.D., F	h. D. Assistant N	/ledical Exam	niner 900	W. Baltimore	Street, Balti	more, MD 21	223	
St	ate	31. Date filed (Month, Day, Y	(ear) 32. Re	gistrar's Signatur	· he as the	J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Willie Physician/ Month 0830 PM JOVEM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP ITAL BALTIMORE AGNES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days 245-48-934 (Month, Day, Year) Director 1 M 2 F or 28e-f ehov permit. Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Heelth end Mentel Hygiene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28e-f ehov i Hygiene. | other then "neturel", or Items 23e or 28e-fehovent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mary lara 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Heelth end Mentel Hygie If Item 27 Is merked other is other treumetic event, # æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unt Rural Route Number City or Town, State, Zip Code) illian Walker 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. pproximate Interval Between nset and Death FAILURE Immediate Cause (Final Pnysician/ RENAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 DAYS Bi Sequentially list conditions, if any, leading to immediate Examine ERTEN SION cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificete be executed been signed by the ettending physician end should be detached for use es the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of hes autopsy performe certificate 2. No 1 Yes director **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. I Director: A ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hoepital or A within 24 hours after To the Funeral Dirac completely filled in b Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AVE, AM AR

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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32. Jegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#5perFH, G936, 2/13/2013, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Saveria Lisuzzo Month 11/16/2012 Physician/ 9:30pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rock Springs Village Forest Hill Harford Social Sourity Number - 34-72 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs._ 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 34-7214 Hours 86 Director 1 🗆 M 💥 F Italy 10/21/26 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Harford Belair 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 1819 Selvin Drive 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Garment Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Giuseppe 2 LoBianco Giuseppina DiNovo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Ingrao Daughter 208 Wagner Road Belair MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green—wood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 K Removal from State 11/21/12 Brooklyn NY 4 Donation 5 Other (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Victor Doda Signature of Funeral Service Licenses no 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i i n disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE 270 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown page 2 should be detached signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence assisted P 2 🛂 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spe within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner_of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed Month, Dav. Year) io completed cause of death (Item 23a) (Type, Print) 32. Registrar Signat State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Irene Lendle 8:45 P M November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 988 Waterview Drive Crownsville <u>Anne Arundel</u> Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Director** 1 DM 2 X F 424-56-0973 70 February 16, 1942 Alabama Usual Residence of Dec should be filed within 12 incomes and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "marked other than "natic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Crownsville 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 988 Waterview Drive 21032 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 Ses 2 No Specify: If Yes. Give White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plastic & Molding <u>Maintenance Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Franklin Day Dorothy Rosson permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Lendle, Sr./Husband 988 Waterview Drive, Crownsville, Maryland 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State west Arundel 1 Burial 2 Cremation 3 Removal from State ō November 29 injury (4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland Crematory 21. Signature of Funeral Service Licen 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. (ARVE M01386 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, or col ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final the lune Physician Metastatic adeno carconona man this disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cell carcinona 1 Yes 2 No 3 Probably 4 Unknown Completed the rectum 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Adeno car cenona autoosy Pueum area 1 ☐ Yes 2 ☐ No 1 Yes 2 VNc 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending WORK? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Brow.on November 29 2012 -ULA D005 8893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hene Browner aus Baltemare, 410 Hospital ohrs

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 26 per phy 9933 11-30-12 sm
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death . 2<u>012</u> Physician/ 4:15A ^M Bobbie Edith Lovens 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Severna Park Center Severna Park Anne Arundel Co. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Director 213-22-1322 1 □ M 2 🗓 F 98 04/18/1914 Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Hanover Anne Arundel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 21076 1512 Beaver Dam Court 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Yes 2 X No 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🗓 No Specify: If Yes, Give White 3 □ Widowed 4 □ Divorced Specify. Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland should be filed with and Mental Hygien is marked other th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Houndshell Elizabeth Pace Andy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is nany injury or other 1512 Beaver Dam Court Mrs. Mary E. David / Daughter Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Mem. Park 12/04/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signul e of Funeral Service Licensee MO1479 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Provincian andas grace disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed and I-tran resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Dav Pregnant at time of death been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes' No has 1 ☐ Yes 2 No this certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 npatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Director: After (Month, Day, Year) 1/ Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hwy Ste 106 Gler Burie MA 1600 S. Crain State NOV 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	larylan		artment of H		and M	ental Hy	giene	10	00010
			State Registrar			Cer	tificate of L	Death			Reg. No.Z U	12	38612
	Physicia	an/	1. Decedent's Name (First, Middle, Addie Mee Lewis	Last)						2. Date of De Month		Year	3. Time of Death
· Anny	Media	cal	4a. Facility Name (if not institution,	aire street and number			15 Cit. Town o	1		November	22, 2012		4:50 a.m.
	Examir	ier	Heartland of Hyat		na Home	Δ .	4b. City, Town, or Location of Death Hyattsville				4c. County	of Death e Geor	1
	Funeral					nst birthday)	If Under 1 Year	If Under		8. Date of Birt	h	9. Birthp	place (State or Foreign
i.	Director		417-24-8668	1 □ M 2 🏋 F	90	Yrs.	Months Days	Hours	Min.	(Month, Da		Coun	try)
	how at] <u>_</u>	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Loc	ation			December	23,1921	Alab	
	arylar la-fsl	ecto		George's	1	tsville	ation						1 X Yes 2 ☐ No
	or 28 e noti	Ē	10e. Street and Number				10f. Zip Code				10g. Citizen of V	What Cour	
	with t 23a ust be	Funeral Director	4824 Avondale Road	l			20782				US	viiat ooui	iu y :
	leath items er mi	F.	11. Marital Status	12. Was Decedent	Ever in U.S		las Decedent of H	ispanic Orig	gin? (Spec	ify Yes or No-	14. Rac	e - Americ	an Indian,
36	", or "	5	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 X			Yes, specify Cuba			ican, etc.)		k, White, e	
8	72 hours after death with the Maryland n "hatural", or items 23a or 28a-f show fledical Examiner must be notified at	Completed by	3 ▼ Widowed 4 □ Divorced	Year or Dates.							Specify:	Bla	€CK
5	72 hc in "ne Medic	mpk	15. Decedent (Specify only highes	t grade completed)		(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation during most	t of working	g	16b. Kind of Bu	isiness/Ind	dustry
212	within giene. er thar t, the N		Elementary/Secondary (0-12)	College (1-4 or	5+)		Worker				U.S. Po	stal S	ervice
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hyglere. If item 27 is marked other than "natur or other traumatic event, the Medical	Be	17. Father's Name (First, Middle, La	st)	1	LIBIAL	WOLKEL	18. Mothe	er's Name	(First, Middle,	Maiden Surname	2)	
ylar	should be file and Mental 7 is marked or raumatic eve	욘	Lester Salter					Matt:	ie Sim	pson			
lan	shoul and l is ma		19a. Informant's Name/Relationshi	,			g Address (Street a						(ode)
≥,	and 2 fealth im 27 her tr		Paula Wade/Daughter	·			Kingswell S	Street	, Mitc	hellvill	e, MD 2072	21	
lore	ge 1 a		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation	3 ☐ Removal from State	20b. Pl	ace of Dispos emetery, crem	sition (Name of atory or other plac	e)	Da	nte	20c. Location -	City or To	wn, State
ţ	tt. Pag rtmen rtant: njury		4 Donation 5 Other (Sp	ecity)			orial Cemet						
Ba	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce.	-	21 Simulture of Funeral Scale Lic	ensee	1		Name and Addres						nc.
		_	23a. Part 1. Enter the disease, or o	omplications that caused	d the death		111 Pennsy)/40	
	Physician/		Immediate Cause (Final	ly one cause on each line	e.			1					Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as	2 conseque	way	Accider Particia Ultres	17				-	
	Examiner			Allogn	clon	of C	adioia	scula	D	1300S0	7		
-	+	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):							
	cuted nd transi	xam	that initiated events	o. Dias	50/05	Me	llibres						
	ate be executed ohysician and the burial-transi	alE	resulting in death) Last	Due to (or as	a conseque	ence of):							
09/	cate be executed physician and sthe burial-transit	edical Examiner		d								_	
Box 687			IF FEMALE:	23c. If yes, outcome	of pregnan	ICV							
XO	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 morths?		2 Fetal	death 3	Ectopic pregnance Other (specify)	у			23d. Dat Mor	e of delive nth	ry Day Year
B.	hat the dea ed by the a detached f	hysi	1 Yes 2 No 9 Unknown	9 Unknown	it time or de								,
P.0.	that t	by P	Part II. Other significant condition	s contributing to death b	out not resu	Iting in the un	derlying cause give	en in Part I		23e. Did to	bacco use contri	bute to the	e cause of death?
ds,	requires that been signed I should be del	edi								1 □ Y	es 2 No	3 🗆 Prob	ably 4 🗆 Unknown
Son	w rec as bee	plet								24a. Was a			sy findings available
Division of Vital Records,	Physician: The law this certificate has al director, page 2	Completed								autop: perfor	med? d	eath?	npletion of cause of
ā	cian: ertific ector,		25. Was case referred to medical examiner?				26. Pla	ice of Deat	h (Check o		Z Up NOI	103 /	
Ż	Physic this c	욘	1 Ves 2 No			R/Outpatient	3 DOA Othe	r: 4 Nu	rsing Home	e 5 🗆 Reside	ence 6 🗆 Othe	r (Specify)	
0	al or Attending P s after death. I Director: After the d in by the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Day		28b. Time of injury	28c. Injury work?	?		d. Describe ho	w injury occurre	d	
Siol	death death stor: /	tific	2 Accident Investiga 3 Suicide 6 Could no	t be	In At hom	an form atros		Yes 2 🗆					
<u>≅</u>	after Direct		4 Homicide determin	28e. Place of Inju- building, etc	c. (Specify)	ne, rarm, stree	я, тастогу, опісе		28	f. Location (St City or Town	reet and Number n, State)	or Rural F	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the	edical	29a. Certifier 1 Certifying P	hysician: To the best of	my knowle	dge, death oc	curred at the time.	date and	place, and	due to the car	use(s) and manne	er as state	d
	n 24 h	Med	(Check 2 \subseteq Medical Exa	miner: On the basis of ea lurse Practitioner: To the	xamination a e best of my	and/or investion	gation, in my opinior leath occurred at th	n, death occ	curred at the	e time, date an	d place, and due	to the caus	se(s) and manner stated.
	withi 70 th		29b. Signature and title of certifier				29c. License	number		2	9d. Date signed	(Mopth, D	ay, Year)
		ı	MD				47	1861		_	11/28	112	
	611	Ì	30. Name and address of person wh	o completed cause of de	eath (Item 2	23a) (Type, Pri	nt)	-	Solle.	11	14 200	21>	
	\mathcal{I}		Unity Filmigo	. 4101 Ra	nocol	Ph Fo	29c. License 47	1 50	CKIN	ce, r	10 00	J C.	
	Stat Registra	6	NOV 3 0 2012		ar's Signatu								
				LINGUICA CI.	1000	A Property							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MENEN 10:10 AM 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR PIKESVILLE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 218-59-6686 1 X M 2 □ F 89 03/14/1923 USSR 2 should be filed within 72 hours after death with the Maryland th and Mentel Hygiene.

27 Is marked other than "neturel", or Items 23e or 28a-f show treumetic event, the Madical Eximiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4204 OLD MILFORD MILL ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force 1 ☐ Yes 2 🖾 No Black White etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) BUTCHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEMENEV CHAYA UNKNOWN 1 and 2 should b of Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROMAN LEMENEV/SON 12 CORNBURY COURT, OWINGS MILLS, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 Depertment of I Importent: If It any Injury or o cemetery, crematory or other place ARLINGTON CHIZUK AMUNO CEMETERY 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause unleach line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a cons, uence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury slcian and burial-transit Exami The law requires that the death certificate be executed that initiated events resulting in death) Last ettending physician I for use as the buria Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the et Id be detached fo 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical funeral director, **Division of Vital** 8 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No မြ After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannes of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Dav. Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature, 29c. License number 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 2 8 5 1 1

			State Registrar			Certificat	te of L	Death	-	Reg. No.	UIZ	30014
	Dhamisis	.,	1. Decedent's Name (First, Middle,	Last)					2. Date of De		Voer	3. Time of Death
	Physicia Medic		Delbert			Morgan			Novemb	er 28	2012	3:00 AM
1	Examin		4a. Facility Name (if not institution,	give street and number)		4b. City	, Town, or	Location of Dea	th	4c. Co	unty of Death	
1			12900 Eastern A					River			altimor	
100	Funeral		· · · · · · · · · · · · · · · · · · ·		n yrs. last birti	hday) If Under Months	Pr 1 Year Days	If Under 24 Hrs Hours Min			9. Birth Cour	place (State or Foreign
	Director		233-54-6100 Usual Residence of Decedent	1 X M 2 □ F	77	Yrs.			3/10/1	935	Wes	t Virginia
	nd how at	占	10a. State 10b. County	10	Dc. City, Town	or Location					<u>'</u>	10d. Inside City Limits
	aryla a-f s fied	ectc	Maryland Baltin		M: AAI a	Dirror						1 ☐ Yes 2 X No
	he M or 28	늅	10e. Street and Number	iore I	миаате	River	p Code			10a. Citizer	n of What Cou	ntry?
	with t	Funeral Director	12900 Eastern A	zonijo		21	220			U, S.		,
	ems r mu	Ĕ	12 900 Lastern A	12. Was Decedent Ever	r in U.S.	13. Was Dece	dent of Hi	ispanic Origin? (S	pecify Yes or No-		Race - Americ	can Indian,
9	or it	by F	1 Never Married 2 Marrie		1953			n, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
93	ırs aff ıral", Exa	- pa	3 \square Widowed 4 X Divorced	If Yes, Give Year or Dates.	1956	1 L Yes	2AL No	Specify:		Spe	ecify: Whi	te
2-0	hou "natu	Bet	15. Decedent (Specify only highes		16a.	Decedent's Usu	ial Occup	ation during most of wo	rkina	16b. Kind	of Business/In	dustry
7	hin 7% ne. than e Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. DO NOT us	e retired)	anny most or me	g	774		_
2	d with	Be C	8		Re	pair Pe	rson				ronics	
anc	ntal Hed o	To E	17. Father's Name (First, Middle, La						me (First, Middle,		,	
Ĕ	uld b d Me mark matic		John Calvin 19a. Informant's Name/Relationshi	Morgan				Laura			Lambe	
Na	2 sho th an th an traul					-			ural Route Numbe	-	•	
ė	and Heal tem (-	Tammy Morris (Da 20a. Method of Disposition			2900 Ea Disposition (Na		Avenue	Date		ion - City or To	rland 21220
DOI	age 1 ent of rt: If i y or o		1 St Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc	3 Removal from State		y, crematory or		e) Cem. 12/3			•	,Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature) of Funeral Service Lie		riaryra	22. Name a			5/2012	CLOWII	SVIIIE	Paryland
B	permir Depar Impor any in		Idn W. Rus	Rounke				i Funer Eastern	al Home	PA	Marvl	and 21221
			23a Part 1. Enter the disease, or o	omplications that caused the	e death. Do n					rest,	PROLYI	Approximate
	Physician/		Mock, or heart failure. List or Immediate Cause (Final	ly one cause on each line.	00	vFD						Interval Between Onset and Death
)	Medical	İ	disease or condition resulting in death)	a. Due to (or as a co	onsequence o	nulli fi					-	
	Examiner	.		. TOBAC	00	MOKI	NS.					
	BUEN.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. Due to (or as a co	onsequence c							
	uted	Examiner	Cause (Disease or injury that initiated events	c								
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8760	tificate be executed ng physician and as the burial-transit	Medical	•	d								
387	rtifica ing p e as t		IF FEMALE: VA	00-16								
×6	ath cer attendi for use	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	☐ Fetal death			y		23d	. Date of deliv Month	rery Day Year
Вох	e dea the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death	5 Other (s	ресіту)				WIGHT	Day 70a
P.O.	requires that the des been signed by the s should be detached		Part II. Other significant condition	s contributing to death but r	not resulting in	n the underlying	cause giv	en in Part I.	23e. Did t	obacco use o	contribute to t	he cause of death?
S, F	signe d be	d by							1 52	Yes 2 \(\simething \) \(\text{N} \)	No 3 🗆 Pro	bably 4 🗆 Unknown
ğ	requi been shoul	ete							24a. Was	on 2	4h Mere auto	psy findings available
ecc	The law ate has page 2:	Completed							auto	psy ormed?	prior to co death?	ompletion of cause of
<u> </u>	n: Th ficate or, pa		25. Was case referred to medical				00 DI		1 🗆 Yes	2 XX No	1 🗌 Yes	2 <u>No</u>
lita	ysician: The law lis certificate has be director, page 2 s	m	examiner?	Hospital:	0 □ EB/O	tpatient 3 🗆 D	Othe	ace of Death (Che			011 60 16	
£	g Phy er this eral o	e: 10	27. Manner of Death	28a. Date of injury	28b. T	ime of	28c. Injury		Home 5X Resi			//
Ž.	nding ath. :: Afte ie fun	cat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga		<i>ear)</i> Ir	njury M	work	? Yes 2□No				
isi	I or Attending Ph after death. Director: After th d in by the funeral	Certificate:	3 Suicide 6 Could n 4 Homicide determin	28e. Place of Injury		m, street, factor	y, office				ımber or Rura	l Route Number,
Division of Vital Records,	tal or rs aft al Dir ed in			building, etc. (S	specify)				City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death cer within £4 hours after death within £4 hours after death this certificate has been signed by the attendit To the Luneral Director. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical		Physician: To the best of my aminer: On the basis of exam								
	the Ithin 24 the F	Me	only one) 3 Certifying I	Nurse Practitioner: To the be		vledge, death oc	curred at the	he time, date and		the cause(s) a	nd manner as	stated.
	vit Coo		29b. Signature and title of certifier	Q. 75	om,	29	c. License			29d. Date si	gned (Month,	Day, Year)
	MALL		Yustoph	A mis	1			34249		11/0	1100	
	71.11		30. Name and address of person w	no completed cluse of death	n (Item 23a) (1	Type, Print)		01	110	0 11	\ _ ~-	10 9193°
	J		31. Date filed (Month, Day Year)	32 Register's	Sio A A K	1944 F	70 10	15 Kd,	17 DUK	ball	10-11	10 alga
	Stat Registra	_	May 3 0 2012	Carrie 15.	19							

	AMEND	#2	PER MD G933 11/30/	pe or Print in Black	Indelible Ink. Ensure	All Copies A	re Legible	
			For State Registrar	State of Maryland / Dep	ertificate of Death	Mental Hygier	ne2012	38615
	Physicia		1. Decedent's Name (First, Middle, Last)	Mauning.	51	2. Date of Death N		12 3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give stre	eet and number)	4b. City Town, or Location of Peat Randalls for	b C	4c. County of Dear	
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 15-34-8585	7. Age (In yrs. last birthday M 2 \square F 75 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day Yea	9. Bir Co	thplace (State or Foreign suntry)
	faryland 8a-f show tified at	rector	10a. State 10b. County	10c. City Town or I	nore		<u>'</u>	10d. Inside City Limits 1 Yes 2 No
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 907 Kevin Re		10f. Zip Code 2/229	10g.	Citizen of What Co	ountry?
9800	within 72 hours after death with the Maryland jene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	5			. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 1 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	1 and 2 should be filed within 72 hour f Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT usgretified OCIAL WORK	rking 16b	Maryla	Indus of
Maryland 2	should be filed wit and Mental Hygie is marked other aumatic event, th	To Be	17. Father's Name (First, Middle, Last	nning	18, Mother's Nai	me (First, Middle, Maid W H. E	est	
	1 and 2 shou of Health and item 27 is m other traum	Ĭ	Hylene I. Wann	ma (Wife) 907	illing Arress (Street and Number or — - Kevin Koad I	Route Number, City	or Town, State, Zi	p Code)
Baltimore,	Page 1 an ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)			Date 15/12 (C)	:. Location - City or	Town, State MD
Balt	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	Greene	Variables Carlles	eche tune	212 Se	29)
	Physician/		23a. Part 1. Enter nedisease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ations that caused the death. Do not encause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (er as a consequence of):	Cancer			
	ted	Examiner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence of]	
90	te be executed nysician and he burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):				
Box 68760	requires that the death certificate be e been signed by the attending physicial should be detached for use as the bur	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
, P.O.	requires that the been signed by the should be detach	by Ph	Part II. Other significant conditions contr	ibuting to death but not resulting in the				o the cause of death?
cords	≥ IS ≤	pletec				24a. Was an autopsy	24b. Were au	Itopsy findings available completion of cause of
al Re	sician: The law i certificate has b director, page 2 s	Be Con	25. Was case referred to medical		26. Place of Death (Che	performe 1 Ves 2	death?	s 2 🗆 No
f Vita	Physicia this cert	မ	examiner? 1 Yes 2 No Hos 27. Manger of Death	pital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing F	lome 5 Residence		cify)
o uo	eath. or: After he funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
	n 24 hou n 24 hou ne Funer	Medical	(Check 2 Medical Examiner	an: To the best of my knowledge, death : On the basis of examination and/or inve tractitioner: To the best of my knowledge	estigation, in my opinion, death occurred	at the time, date and pla	ace, and due to the	cause(s) and manner stated.
	To the within cong.		29b. Signature and title of certifier		29c License number	204	Date signed /Mont	Day Vear
			30. Name and address of person who com	Noted cause of death (Item 23a) (Type,	D46374	Rd 8	and a/	Troum MO
	Star Registra		31. Date filed (Month, Day, Year)	32. Jegistrar's Signature	barre			/ 40. (1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Meding Garnet Virginia November 2012 1:07 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 73 Admiral Boulevard Dundalk BAltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 236-16-9952 1 □ M 2 🛣 F Director January 16,1921 Kentucky 91 Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

Sent: If item 27 is marked other then "neturel", or items 23e or 28e-f show ury or other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Dundalk Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 73 Admiral Boulevard 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 2 years 12 years Executive General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Blanche L. Matheny Glenn P. Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Rappazzo Daughter-In-Law 73 Admiral Boulevard, Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e Department of H Importent: If ite eny injury or ot 20c. Location - City or Town, State November 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Baltimore, Maryland BAyview Crematory 30, 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): slcian and burial-transit or Attending Physicien: The law requires that the death certificate be executed Exami that initiated events Due to (or as a consequence of): resulting in death) Last ettending physician I for use es the burial Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 🔀 No Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year)

State Registrar

104

Maryland

4940 EASTERN AVE.

DiD067635

BALTIMORE

NOV

2012

MD

JH BMC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jessica Colburn

NOV

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 10:15 AM Dorothy Bernadine Moritz November 28, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Howard County Howard Columbia 8. Date of Birth (Month, Day, Year, Jul 06, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Country) Maryland Days Hours Min 90 Director 215-16-2354 1 M 2 KF 1922 r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at permit. Page 1 end 2 should be filed within 72 hours after deeth with the Meryiand Department of Heeith and Mentai Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 2913 Green Way Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Heeith and Mentai Hygiene. item 27 is merked other than ' other traumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas W. Summers Ellen W. Walsh f Heeith and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Wehner /Daughter 5351 Smooth Meadow Way Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State important: if if any injury or o 1 Burial 2 Cremation 3 Removal from State Dec 4 ☐ Donation 5 ☐ Other (Specify) Baltimore. 2012 Loudon Park Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives Kelbec sacke 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Mycardial In Immediate Cause (Final Jarelion Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hoapital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for the burners. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stage dementia 1 Yes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of contifier as D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 Q ABBAS CEDAR ANE OWMBIA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

MAY 3 O

DHMH 17 Rev 06-2011

Maryland 21215-0036

Box 68760

Division of VItal Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month McGowens Gail 21:10 M Medical UO 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 17. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 213.58.2880 Director 1 M 2 F 07 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28e-f ahow traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Battimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Tevis Circle 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced If Yes, Give Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Western Electric 12th grade Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James A. Morean Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Gilbert McGowans/Husband 3910 Tevis Circle Randallstown Mp 21133 permit. Page 1 and 2 Department of Health Importent: if item 27 eny injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 2012 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee, 8728 Liberty Road Randall Jown MD 21133 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner -0-1-0 1 en-Sequentially list conditions. if any, leading to immediate raise Fitter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physician and for use as the burlal-transit Renau that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 10-100 11-cont-C 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 Wo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed Thrombus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗖 No Other: မှ 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No iours efter death.

nerai Director: Aft
filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours e To the Funeral Completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 02908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Bay, Year)

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	Funeral Director			6. Sex 7	. Age (In yrs. Is	ast birthday)	If Under Months		If Under 2		8. Date of Bir (Month, Da		9		ace (State or Fore	ign
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90	e be executed lysician and ne burial-transit	ल	resulting in death) Last	Due to (or	as a consequ	ience of):										
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transitely filled in by the funeral director.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta ntattime of d	Ideath 3	Ectopic pr Other (spe		,				23d. Date o Month		ay Year	
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Division of Vital	al or Atter s after des I Director d in by th	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of	Injury - At ho , etc. (Specify)					-	8f. Location (S City or Tou			r Rural R	oute Number,	
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	5M		30 Name and address of berson w	ho completed cause of	of death (Item	23a) (Type, Pr	int)	04	B	all	ima	20	Mi	D-7	1234	
	Stat Registra	•	31. Date filed (Month, Day, Year)	2012 32.189	istrar's Signati	J. A	are)	,	,	-					-)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First_Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-84-2197 Days Director i ☐ M 2XXX 48 Yrs 12/30/63 MD 28a-f shov items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore 1XXXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1710 William Street 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should .e filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natu any injury or other traumati: event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rollins Betty J. McLemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Gollock / Sister 1811 Light Street, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) Cremation Center of MD 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 11/27/2012 Hanover MD 4 Donation 5 Other (Specify) signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, 1 1501 E. Fort Avenue, Baltimore MD **V** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ concer una Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the attending physician and ched for use as the burial-transii Cause (Disease or injury certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 Yes 2 No ☐ Yes 🔁 To the Hospital or Attending Physician: "within 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) 6 Nother (Specify) 1 ☐ Yes 2 ☑ No Hospital: Other: ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1- Natural (Month, Day, Year) 5 Pending injury 2 ☐ Accident 3 ☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Providing of the Cause (s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nsilajapa meun DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD 2835 Smith N NSKujapaksemo 5703 31. Date filed (Month, Day, Year) State NOV 3 0 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, Choate Michael 2012 Barbara 11:10 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford 7.62 Henderson Road Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min (Month, Day, Year) Director 212-22-9386 1925 87 26, Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 No No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 762 Henderson Road 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If them 27 is marked ofth any Injury or other traumetic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gertrude Evelyn Joines Oscar (nmn) Choate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 762 Henderson Road, Bel Air, Maryland 21014 Bernard H. Michael III 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Bel Air Memorial Gdn. 12/1/2012 Synatur Funera 22. Name and Address of Facility McComas Funeral Home, P.A. Bel Air, Maryland 21014 Broadway, 50 W. Part 1. Enter the disease, or complication shock, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. or complication Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician CONGES disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner 4 EARS Securatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death JYes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes ည 2 1 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending death. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 24 hours Medical To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b Signature and title 29c. License number 29d. Date signed (Month, Day, Year) w(no completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

filed (Month, Day, Year) NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State of Ma	aryland /		artment of F tificate of L		viental Hy	giene Reg. No	2012	38623
Physici		1. Decedent's Name Judith	e (First, Middle, Last Lynne Mai	,					2. Date of De Month Novemb		ž6, 2012	3. Time of Death 0645 M
Medi Exami		4a. Facility Name (if	not institution, give	street and number)			4b. City, Town, or Location of Death Silver Spring			4c. County of		1
Funeral		414 Wate: 5. Social Security Nu		x 7. Age	e (In yrs. last bi	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	ontgomer 9. Birti	Y nplace (State or Foreign
Director		220-56-70 Usual Residence of	026	☐ M 2 🔀 F	60	Yrs.	Months Days	Hours Min.	Mar 12	y, Y qa 95	52 Wash	ington, DC
fand fshow dat	tor	10a. State	10b. County		10c. City, Tov	vn or Loc	cation					10d. Inside City Limits
e Man r 28a-i notifie	Direc	MD 10e. Street and Num	Montgome	ry	Silver	Spr	ing 10f. Zip Code	. –		10 0"		1 🗆 Yes 2 🚨 No
with th s 23a o ust be	Funeral Director		rford Roa	d			20901			USA	tizen of What Co	untry?
DEJILITIOTE, INIGITY I SIGN CALLED-UUSO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	þ	11. Marital Status 1 Never Marri 3 Widowed	ied 2 🏿 Married 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		- 1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🎛 No	Ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.
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yiand , id be filed \text{Mental Hygarked othe attic event,}	To Be	17. Father's Name (F	First, Middle, Last) Adlai Man	n	•			18. Mother's Nam		Maiden	Surname)	
aryi hould the and Me is mark	ľ	19a. Informant's Na	me/Relationship (Ty)	pe, Print)	19	b. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	er, City or	Town, State, Zip	
e, IV and 2 s Health em 27 ther tre		Gantt Ku 20a. Method of Disp	shner/hus	band			Vaterford	Road Si.			-	901
Dallilling Department of Mportant: If it any injury or of		1 ☐ Burial 2 0 4 ☐ Donation	X Cremation 3 ☐ 5 ☐ Other (Specify		cemet	erv crem	natory or other place mey Crem	(e)	Date 1/29/12		dbine, M	
permit Depar Impor any in		21. Signature of Fur	neral Service License	Le Offe	MO125	<i>G</i> c 51 Be	Name and Address oing Home everly L.	E Cremation	on Servi	ice . Cla	P.O. Bo arksvill	x 784 e, MD 21029
			t failure. List only on	lications that caused the cause on each line	the death. Do							Approximate Interval Between Onset and Death
- Physician/ Medical		disease or condition resulting in death)		a. Motasta Due to (or as a	tic Lur a consequence		ncer					
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De exec ician ar burial-tr	edical Examiner	resulting in death) L	ast	Due to (or as a	a consequence	of):						
of our		IF FEMALE:		d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 n 1 Ves 2 X 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnance Other (specify)	у			23d. Date of deli Month	very Day Year
that th	by Ph	Part II. Other signifi	cant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco u	use contribute to	the cause of death?
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s certifica	Be	25. Was case referre examiner? 1 Yes 2 X	- T	Hospital:			Othe	ace of Death (Chec	k only one)			
O V O Phys ter this neral di	te: To	27. Manner of Death	1	1 ∐ Inpatie 28a. Date of Injur (Month, Day	ent 2 ER/C ry 28b.	Outpatien Time of injury	t 3 L DOA 28c. Injury	4 □ Nursing Ho / at	ome 5 XResi 28d. Describe l		Other (Special occurred)	fy)
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tal or A	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Notice) City or Town, State)									al Houte Number,		
he Hospi in 24 hou ne Funeri pleted filli	Medical	(Check 2		ician: To the best of ner: On the basis of exe e Practioner: To the	kamination and/	or investi	gation, in my opinio	n, death occurred a	t the time, date a	and place,	, and due to the c	ause(s) and manner stated.
To the withing the company of the co	_	29b. Signature and t										
Mak		30. Name and addre	ess of person who co	ompleted cause of	eath (Item 23a)	(Type, P	rint)	1110		NOI	EMBER	<i>47 2012</i>
a Mill		G. Col	EMAN 1	M.A 600	1 Mu	ncas	ster Mi	11 Rd R	ockville	M	D 2085	Day, Year) 27 20/2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Maurice Reginald Marable 1:28A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 4306 Concept Court anham If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 **Funeral** Months Hours Min. (Month, Day, Year) 578-96-6219 1 XM 2 □ F **Director** Yrs 50 11-25-1961 DC Usual Residence of Decedent show 10d. Inside City Limits the Maryland aţ 10a, State 10c. City. Town or Location Director notified 28a-f 1 X Yes 2 No Prince George's Lanham MD 10e Street and Number 10f. Zip Code 9 10g. Citizen of What Country? is 23a or ∢r must b Funeral with 1 20706 4306 Concept Ct. items 2 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian "natural", or iter edical Examiner Armed Force Black White, etc. þ 1 Never Married 2 X Married Yes 2 XNO Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Roadway Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If item 27 is marked other thau ury or other traumatic event, the N Truck Driver Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Marable, Sr. Melanise Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Concept Ct. Lanham, MD 20706 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once, Selma Marable/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Lincoln Memorial Cem. 11/23/2012 4 Donation 5 Other (Specify) Suitland, MD re of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home Washington, DC 20011 4217 9th Street NW, 23a. Left 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bowel Obstruction weeks disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 12 months Metastatic Colon Cancer Sequentially list conditions, Examine If any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ should be Inanition, Cancer Cachexia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Insufficiency 24a Was an Hepatic page 2 autopsy performed? Yes 2 X No 1 Yes 2X No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 🗌 Yes 2 [**X**No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the within 24 hours after deathor:

To the Funeral Director: 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 15185 11/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving St. NW Ste 2200N, Washington, DC 20010

Registrar DHMH 17 Rev 06-2011

State

MD

32. Registrar's Signature

Joan McKnight,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Jung Ja Milburn 20^{rear}2 6:00 AM Medical Nov. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death
Baltimore Middle River 12726 Cunning Hill Cove Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth ocial Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 555-74-6748 Days Hours Feb. 2, 1934 Country pan Director 1 M 2 X F 78 Usual Residence of Dece Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 12726 Cunning Hill Cove Road Japan 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ^{Specify:} Asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 4th permit. Page 1 and 2 should be filed witi Department of Health and Mental Hyglei Important: If item 27 Is marked other I any Injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Towa, State, Zip Code) 5325 Litany Lane Baltimore MD 21237 Angel Smith / daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)
Bayview Crematory 11/26/12 20c. Location - City or Town, State 1 🗆 Buriał 2XXI Cremation 3 🗔 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 complications that car sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, Approximate shock, or heart failure. List Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ENCEPHALO PATH Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 🔲 Ectopic pregnancy 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Day After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🔲 Yes 2 -140 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗆 Yes 2 🗆 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) edical 1: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 255306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 Rd Soute 200 Brillmore 31. Date filed (Month, Day, Year) State MOA Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2017 1:52 AM LEO A. MENINGER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square osedale Baltimore Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) **Director** 85 220-18-4217 1 X M 2 - F JUNE 21,1927 MARYLAND Usual Residence of Deced ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTIMORE BALTIMORE 1 Yes 2 x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5128 FARNSWORTH PLACE 21206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates 1945—1946 1 Never Married 2 X Married δ Meninger, Leo Baltimore, Maryland 21215-0036 WHITE and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10TH **FOREMAN** ESSKAY MEAT CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. once. JOHN MENINGER ROSE ROSENBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY MENINGER SPOUSE 5128 FARNSWORTH PLACE BALTIMORE, MD. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Removal from State 4 Donation 5 Dotter (Specify) DULANEY VALLEY 11-28-2012 TIMONIUM, MD. SCHIMUNEK FUNERAL HOME INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ oscleratio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mineulate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death director, page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ျပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check 3 Certifying Nu within 2 To the only one) se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a d title of certific 29d. Date signed (Month, Day, Year) NOVEMBER 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) DR. MICHAEL ZANG 7602 BELAIR ROAD BALTIMOE, MD. 21236 31. Date filed (Month, Day)

State Registrar

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harmon 3 3 36 PM Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death Medical Mercy altimore t Center 1 Year I If Under 24 Hrs. 8. Date of Birth
(Month, Day, Ye
NOV 15, 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** N/A 1 🗆 M 2 🕱 F Min. Director Nov 201 Usual Residence of Decedent 28a-f show 10a. State 10b. County City, Town or Location
Baltimore notified at 10d. Inside City Limits Director MD Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21217 517 Cumberland St. USA 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Saltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 🖁 No If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) O N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Brandon Windham Melodee Norris 19a. Informant's Name/Relationship (Type, Print)
Melodd Norris/Mother Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 7 Cumberland St. Baltimore, Md 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date metro Crematory or other place) 11/30/12 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Service 22. Name and Address of Facili Reverly D. Cromartie F/S 2700 Edmondson Ave. Balto., 21223 art : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine frany, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and-trar attending physician cian/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months?
1 Yes 2 No ď Month Year Pregnant at time of death 5 Other (specify) the Physi ed by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy perform Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Paca St, 85-141, Baltimor

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:15р м 20° 20⁴1°2 Doris Bernice Nelson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 2910 Reisterstown Rd. Apt.1L 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days Hours 409-92-3532 Director 1 □ M 2 🖫 F 61 Yrs. 11/16/1951 Knoxville, TN 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Baltimore N/A MD 1 Tyres 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2910 Reisterstown Rd. Apt.1L U.S.A. 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Transcriptionist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 Charles Nelson Sarah Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is Hickory Ridge Ct. Catonsville, MD 21228 Howard Nelson (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/1/12 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
JOSEPH H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave. Balto.,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death ed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🛭 Residence 6 🗆 Other (Specify) 2 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mo

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

legistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 38629 Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 1/28/2012 3. Time of Death Physician/ -WTOK Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 414 Maple Lane NW Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours Days Min 220-07-1900 93 Director 1 □ M 💹 F 5/10/1919 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2XXX No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Maple Lane NW 21061 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify: XX Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Claims Adjuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Johnson Catherine Albrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kevin Newton / Son 1732 Quantico Road Edgewater, MD 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/5/2012 Glen Burnie, MD 21. Signatur Juneral 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, Approximate shock, or heart failure. List only one cause on each line terval Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): I Director: After this certificate has been signed by the attending physician d in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Tes 22 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Hospital or At 24 hours after of determined City or Town, State 24 hours Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 ne and address of person cause of death (Item 23a) (Type, Print) mpje NNAPOLIS MOZITUI 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 9:05 A_M Physician/ october 30 20 Year 2 POWELL PATTON CAROLYN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Examiner Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) ocial Security Numbe If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) 283-18-4580 Hours 10/10/20 92 **Director** 1 🗆 M 2 🔀 F TN 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene.
27 is marked other than "naturel", or Iteme 23e or 28e-f show treumetic event, it e Medical Even in must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ¥ Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1820 Latham Drive 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2x ☐ No Specify: Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Dir. of Teacher Personal 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) School Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Health and Mental F ! Item 27 is marked o Tom Powell 2 Hatley Tommy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Waterside Drive, Frederick Maryland 21701 Gill /Daughter Carol 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Pege 1 permit. Pege 1 Depertment of Importent: If it eny injury or o Ottawa Hills Mem. Park Cem. 11/17/2012 Toledo, 1 Burial 2 Cremation 3 A Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Vicroe Doda charles L. Stevens Funeral Home,)1 CD 1501E. Fort Ave. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physicien and for use as the buriel-transit Exami Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Coronan 1 Yes 2 No 3 Probably 4 Unknown arter been sign Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hes pege 2 autopsy After this certificete 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 Z No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fu 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little of certifier

State Registrar Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

29c. License number

D 5164

29d. Date signed (Month, Day, Year)

10/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 12, per fh, g934 12-7-12 sm State of Maryland / Department of Realth and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Payne Osborne A. 2012 01:52 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchirst Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 229-24-9299 Director 1¥ M 2 □ F 87 Yrs. VA 05 26 25 Usual Residence of Decedent fshow 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Columbia 1 🗌 Yes 2 🔀 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 4931 Pale Orchis Ct. 11. Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc.
Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin auces. 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) McDonald's College (1-4 or 5+) 5yrs+ Elementary/Secondary (0-12) Owner Franchise 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Georgie Sharpe Emmanuel Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4931 Pale Orchis Ct, Columbia, Md 21044 Famebridge C. Payne-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 /30/201 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that collect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ KESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within Fuheral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlansit resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No ျ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1411 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination aria/or envestigation.
3 Certifying Nurse Practitioner: To the best of my knowledge doubth only one oncomed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) D72139 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MD 21044 SYED Q. ABBAS MD 6336 LANE CEDAR 31. Date filed (Month 3 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Nov. Pope (nmn) Platis 22 2:30 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min **Director** 164-24-8298 1 🗆 M 2 🔀 F Nov. 17, 1929 Pennsylvania Usual Residence of Deceden f show artment of Health and Mental Hygiene. ortant: I fitem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 410 East MacPhail Road 21014 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony (unk) Markopoulos Irene (unk) Niamonitakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Rena Beckhorn / Daughter 700 Frans Drive, Abingdon, Maryland 21009 Important: If iten any injury or ... 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 11-26-2012 Baltimore, Maryland Demetrios Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** strointes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin physician and the burial-transit unknown rohns Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? for Month Pregnant at time of death the ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗌 No 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ျ 1 Inpatient 2 FER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? e Funeral Director: Aft bletely filled in by the fur 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesopeo

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 01ney Medstar Montgomery General Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min (Month, Day, Year) 215-52-7299 1 X M 2 □ F Director April 27, 1950 New York 62 Yrs Usual Residence of De ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20853 United States 14221 Chadwick Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married ģ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Doris McGuffey Irvin Plough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pennsylvania 17821 1704 Toby Run Road, Danville, Mary Harris/Sister other 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State November Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Fundal Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 gratte M01305 AR Approximate Interval Between Onset and Death 23a. Part 1/Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and id be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 Mann of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No death. 2 Accident Investigation after death Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I Certifying Nurse 20d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

who completed cause of death (Item 23a) (Type, Print)

4 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,20b per 1h g933 11-30-12 vt. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dav 11:30 AM Medical Larry Paul Roichert

4a. Facility Name (if not institution, give street and number) November 23, 4c. County of Death Examiner 4b. City, Town, or Location of Death 554 Beck Avenue If Under 1 Year If Under 24 Hrs. Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-48-4585 Months Days Hours Min (Month, Day, Year) Country) Director 1**X**M 2 □ F 65 Yrs. Sep 22, 1947 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 554 Beck Avenue United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) **Engineering** Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Frank Reichert Ruth Elizabeth Trentler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antkowiak /Daughter MD 21128 Lori 9925 Richlyn Drive Perry Hall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 30 1 Burial 2 Cremation 3 Removal from State Nov 2 4 ☐ Donation 5 ☐ Other (Specify) 2012 Beltsville, Maryland Checapeake Crematory
22. Name and Address of Facility Signature of Funeral Service License Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carolac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cretaria Onset and Death Physician/ disease or condition resulting in death) 2200 · Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1

Yes 2

No 3

Probably 4

Unknown **Director:** After this certificate has been sid in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 019719 LUIL ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl PURPLIC JHBVML MILHARL 31. Date filed (Month, Day, Year)-State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 70dgeRS 01 2010 :22A M Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death red, CAL Cen Lt.nuRe alt. more Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Day, Year) Director 212-32-6746 Usual Residence of Decedent 1 ☑ M 2 ☐ F 74 02 11 38 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD 1 X Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4605 Coleherne Road 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

M☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sorting Supervisor 2th grade USPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adolphus Rodgers Jr. Mildred Mary Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa R. Rodgers-Wife 4605 Coleherne Road, Baltimore, Md 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrson Forest Vet 11/29/20**1**2 Owings Mills, Md Signature of Funeral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a Part 1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transi The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗆 No 1 🗹 Natural 5 Pending injury Division 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREa 10 M 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark Christopher Ra	adloff State of M 1-For State Registrar	aryland / Department o <i>Certificate o</i>		lygiene Reg. No.	2012 3863
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Mark Christophe:	r Radloff		Date of Death Month Day November 25, 2	3. Time of Death
	4a. Facility Name (if not institution, give street 103 Cow Hide Circle	·	4b. City, Town, or Location of Death Middle River	E	c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 1 1 X M 2	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	/DD/YYYY) 9. Birthplace (State or Foreign Country)/ID
d tow any	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon	10c. City, Town or Loca			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 103 Cow Hide Circ		10f. Zip Code 21220		izen of What Country?
items	1 Never Married 2 Married 1	rmed Forces? If Yes 2X No	as Decedent of Hispanic Origin? (S 'es, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
2 hours after "natural", IExaminer	3 Widowed 4 X Divorced If Yes, or Date 15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	est grade completed) 16a. Decede	Yes 2 No specify: nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret		Specify: White Kind of Business/Industry
5-0036 lied within 72 hour Hygiene. I other than "natt the Medical Exan Completed	1 2 17. Father's Name (First, Middle, Last)	0 Roads		e (First, Middle, Maiden	ate Hwy. Admin.
MD 2121 d 2 should be fill th and Mental H n 27 is marked umarite event,	Wolfram Radloff 19a Informant's Name/Relationship (Type, Pr Wolfram Radloff		Norma g Address (Street and Number or Y Yvonne Ave,	Rural Route Number, C	
c d # .	20a. Method of Disposition 1 Burial 2 X Cremation 3 Rer	20b. Place of Dispo crematory or o	sition (Name of cemetery, ther place)	Date 20c.	Location - City or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite Imjury or other the injury or other the Imjury or other the I	4 Donation 5 Other Specify: 21. Signatur Fungfal Columnsee	22 P a	Crematory 11/ Name and Address of Facility Orkview Funera 527 Harford Rd	1 Home &	Cremation Srvc.
Physician /Medical xaminer		s that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest, she	ock, or heart Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):			
uted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last	(or as a consequence of):			
68760, certificate be executed inding physician and use as the burial - transit cian/Medical Ex	IF FEMALE: 23c.	NDED 23a, pt. II, 27, po	er me,g934 12-10		3d. Date of delivery
Box 68760, he death certificate by the attending physic hed for use as the burthy sician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	Prognant at time of death	etal death 3 Ectopic pregn ther (Specify)	ancy	Month Day Year
P.O. Box res that the death signed by the atte be detached for a	Part II. Other significant conditions contril Hepatitis C Virus	outing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 V Unknown
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending physimeral director, page 2 should be detached for use as the burs. To Be Completed by Physician/Menr.				24a. Was an autopsy performed?	
	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	inpatient 2		ing Home 5 Reside	ence 6 🗹 Other: Scene
	1 X Natural 5 Pending 2 Accident Investigation	a. Date of Injury (Month, Day,Year) 28b. Time of	1 Yes 2 No	28d. Describe how inj	
	4 Homicide determined	Be. Place of Injury - At home, farm, strees Specify) the best of my knowledge, death occurrence.		or Town, State)	and Number or Rural Route Number, City
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the	basis of examination and/or investigation and anner stated.	ation, in my opinion, death occurred	at the time, date and pl	lace, and due to the cause(s)
	29b. Signature and title of certifier A Stanse (29c. License number O.C.M.E.		Date signed (Month, Day, Year) vember 26, 2012
R	* * * * * * * * * * * * * * * * * * * *	nt Medical Examiner 900 V	V. Baltimore Street, Baltim	ore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) NUV 3 0 2012	32. Rejustrar's Signature	ari		
DHMH 17 Rev 1/2001	0045	ORIGINA	L		

12-08337 William Schopp Ple

ease Type or Print in Black Indelible Ink.	Ensure All Copies Are Legib	le.	00007
State of Maryland / Department of He	ealth and Mental Hygiene	2012	38637

		1- For State Registrar	Certific	ate of	Death			Reg	J. No.	
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last) William Joseph	Schopp					Date of Death Month November		0044 nrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center		4	b. City, Town Baltimore		of Death		4c. County o	Death
Funeral Director		5. Social Security Number 137–68–2702 6. Sex 7. Ag	e (In yrs. last birt	thday) Yrs.	If Under 1 \	ear If Unde Days Hours		 Date of Birth 4/27 		Birthplace (State or Foreign Country)
and show any		Usual Residence of Decedent 10a. State	10c. City, Town	or Location	on	Rol	obins	ville		10d. Inside City Limits 1 X Yes 2 No
he Marylan or 28a-f s	Director	10e. Street and Number 130 Wyndham Place			10f. Zip Cod		3691	100	g. Citizen of Wha	at Country? USA
er death with the Maryland , or items 23a or 28a-f sho r must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year		If Ye	Decedent of s, specify Cu	ban, Mexican		cify Yes or No- ican, etc.)	14. Race - White,	American Indian, Black, etc. White
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade come Elementary/Secondary (0-12) 12 College (1-4 or 9)		Decedent during mo	s Usual Occu	pation (Give life. DO NOT	use retired		16b. Kind of Bus	siness/Industry State Agency
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Robert D. Schopp		<u></u>			's Name (F aren		aiden Surname) Vallover	
MD 21; d 2 should b lth and Men n 27 is mar! numatic eve	2	19a. Informant's Name/Relationship (Type, Print) Karen Schopp / Mot	her	b. Mailing 16				ral Route Numb Hamilt		n, State, Zip Code) 08690
s l an sf Hea		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	cremat Ewi	ng Ci	remato	-y	11/	12/12	Ewing	City or Town, State Township, NJ
Baltimo permit. Page Department of Important:		21. Signature of Funeral Service Licensee Victor		1 1	501 E	Fort 7	10001	e Ralt	l Home, imore M	D 21230
Physician Medical Examiner		Part I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a. Hemopericardiu	m	ot enter the	e mode of dyi	ng, such as c	ardiac or re	espiratory arres	st, shock, or hea	Approximate Interval Between Onset and Death
	_	or condition resulting in death) Due to (or as a conse b. Aortic Dissectio Due to (or as a conse b. Aortic Dissectio Due to (or as a conse Due to (or as a conse Due to (or as a conse Due to (or as a conse	n							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
760, ficate be executed g physician and s the burial - transit	dical E	d. UNPENDED AMENDED								
lox 68 eath certi attendin for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23d. Date of delive Month								delivery Day Year
r, P.O. E ires that the d signed by the	至	Part II. Other significant conditions contributing to death	but not resulting	g in the ur	nderlying caus	se given in Pa	nrt I.			oute to the cause of death? Probably 4 Unknown
Division of Vital Records, to or Attending Physician: The law requir rs after death. *I Director: After this certificate has been seled in by the funeral director, page 2 should	Completed							24a. Was ar autopsy perform 1 Yes 2	pr ned? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital: 1 Inpatie	nt 2 🗸 ER/O	utpatient		Other	(Check on Nursing I		esidence 6	Other:
of Viing Physical Control of Viineral dir	입	27. Manner of Death 28a. Date of Inju	ry 28b.	Time of In		njury at Work	? 28		w injury occurre	·
	Certification:	Suicide Could not be	jury - At home, fa	arm, street	., factory, office	Yes 2		Bf. Location (Stror Town, Sta		r or Rural Route Number, City
Red 9 5 29a Certifier										
To th withir To th compl	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	nination and/or i	nvestigatio	29c. Lice	ense number	curred at ti		29d. Date signe	d (Month, Day, Year)
20m		30. Name and address of person who completed cause of d	eath (Item 23a)		0.	C.M.E.			November 5), 2012
		Ana Rubio M.D., Ph. D. Assistant Medic 31. Date filed (Month, Dev. Year) 132. Registra			W. Baltime	ore Street,	Baltimo	ore, MD 212	223	
St Regist	ate rar	NOV3 0 2012 Augusta	r's gignature	ver						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LUCH RAVEN COMMUNITY LIVING MOK Social Security Number 420–38–8834 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 8/10/33 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 79 1 ፟ M 2 ☐ F ALUsual Residence of Deceden or 28a-f shov 10a. State filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medica Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Colbert Tuscumbia 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 East 7th Street 35674 **USA** 12. Was Decedent Ever in U.S.
Armed Forces?

1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates. UNK. 1 ☐ Yes 2XXXNo Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglene, I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Metal Manufacturing Superintendent Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame)
Blanche Warren 17. Father's Name (First, Middle, Last) Unk. Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derrick Southard /Son 4418 Roland Spring Drive, Baltimore MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗀 Cremation 3 🖾 Removal from State Tri Cities Mem. Gardens 12/7/2012 Florence, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Charles L. STevens Funeral Home, निय 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day 2 🗌 No 9 Unknown g 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif Deishmi 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLUD 3900 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 9:15A M Margaret Medical Sellers 2012 28 Nov 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7673 Pine Haven Pasadena Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Day, Y June 01 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours Min. Year) 1921 Director 220-24-2136 MD 1 | M 2 | X F 91 ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7673 Pine Haven 21122 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 📈 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 | alth and Mental Hygiene. 127 Is marked other than "n r traumatic event, the Medi (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Household Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Snyder John Meck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 I Pasadena, Md. 21122 Robert A. Sellers (Son) 7673 Pine Haven 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e
Department of H
Important: If ite
any Injury or ot 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loundon Park Cem. Baltimore, Md. 12/3/12 21. Signature of Fun 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter th hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease, or cor Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition wholish ulmmai Physician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 쥰 Records, 1 Yes 2 LH6 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? 24 hours after death.

2 hours after death.

Funeral Director: After this certificate the fellow filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 ANO **Division of Vital** or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 🗌 Yes 2 3 10 |@ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical the Hospital 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funel completely fi (Check 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

NOV

2106

npleted cause of death (Iten 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3/2012 08 11 Ruth Olive Stilwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ м 🍇 🎇 04728/1926 Pennsylvania 196-26-3134 Director 86 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Harford Havre de Grace MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4141 U-Way U.S.A. 21078 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced Maryland 21215-00 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholseale Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Stilwell Sarah M. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Sugarbush Lane, Coram, NY 11727 19a. Informant's Name/Relationship (Type, Print) Robert E. Stilwell 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 11/19/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service License Washington St Havre de Grace. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 No Hospital or Attending Physician: The certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? a No Other: 4 Nursing Home 5 Residence 6 Other (Specify မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title

30. Name and addres

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Lay 10 2012 Schultz Vivian T. . 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Potomac Valley Nursing Center Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In yrs. last birthday) Hours Days Min (Month, Day, Year) Director 458-64-2575 1 ☐ M 2XXF 88 1924 May 28, Bulgaria ir then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Rd. 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 5 1 Never Mamied 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Medicine Medical Doctor permit. Page 1 and 2 should be filed w Department of Health end Mental Hygi Importent: If Item 27 le marked other eny Injury or other treumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Daskalov Nevena Daskalov Strachmir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 4910 Massachusetts Ave.NW, #215, Washington D.C. Francis E. Fenwick / Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 11/16/2012 Beltsville, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Rapp Funeral and Cremation Services M00382 Xolis How. 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician FAILURE TO THRIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ADVANCED DEMENTIA Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto for as a consequence of ete has been signed by the attending physician and page 2 should be detached for use as the burlal-transit lor Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 0 Box 68760 ce IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who Day Pregnant at time of death 5 Other (specify) g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON'S DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificete has autopsy 24 hours after death.

Funeral Director: After this certifice letely filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred injury 1XXNatural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F

Registrar

only one 29b. Signature a

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signa

MARICHU T. A. MATAS, M.D., 10110 MOLECULAR DR., #206, ROCKVILLE, MD

29c. License number

29d. Date signed (Month. Day. Year

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Maryland Registrar		artment of H <i>tificate of D</i>			jiene Reg. No. 2 ()	112	38642	
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea	th	- Year	3. Time of Death	
5°E ,	Medic	al	Anna Marie Skinner 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Leasting of Dogsth	Novembe			2:00 P M	
	Examin	er	3323 North Furnace Road	Jarrettsville					4c. County of Death Harford		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	g. Birthp	nlace (State or Foreign try)	
	Director		217-24-7857 Usual Residence of Decedent	Yrs.			Dec. 2,	1928	Mary	land	
	f shov	io	10a. State 10b. County 10c. City, T	own or Loc	cation				1	0d. Inside City Limits 1 ☐ Yes 2 🎽 No	
	r 28a- notifie	Direc	Maryland Harford Ede	gewoo	d 10f. Zip Code			10g. Citizen of	What Cour		
	with the 23a oust be	Funeral Director	1914 Juniper Road		21040			USA	Wild Godin		
	death items ner mu		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ		
336	s after al", or Exami	d by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give	1	☐ Yes 2 🔼 No		Specif		hite		
2-0	2 hours "natur dical	Completed		16a. Deced	lent's Usual Occupa	ition uring most of work	ing	16b. Kind of E	Business/Inc	dustry	
21215-0036	ithin 7: ene. r than	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	life DC				Civil	vil Service		
nd 2	filed wall Hygard of otherwent,	Be	17. Father's Name (First, Middle, Last)	Deole	January	18. Mother's Nam	e (First, Middle, I		·· · · · · - · - · - · - · ·		
ylaı	Ment Marker Marker	입	William J. Jackson Jr.			Sarah S					
Mai	2 shouth and 27 is running traum				ig Address (Street a North Fu r						
ore,	of Hea of Hea fitem rothe		20a. Method of Disposition 20b. Plac	e of Dispos	sition (Name of natory or other place	!	Date	20c. Location			
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Bel	Air M	emorial (3dn 11-3					
Bal	permit Depar Impor any in		21. Signature of Juneral Service Licensee		Name and Addres 317 Cokes				-		
П			23a. Part 1. Enter the disease, or complications that cause the death. I shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between	
Ew I	Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a coll sequent)	a	nce				-4	Onset and Death	
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	n to	niner	cause. Enter Underlying	Due to (or as a consequence of):							
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3876	ertificat ling ph		IF FEMALE: 23c. If yes, outcome of pregnance								
Box 68760	ath certifica attending p	Physician/M	in the past 12 months? 1 Live Birth 2 Fetal of 4 Pregnant at time of dea	leath 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	ery Day Year	
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tall	ician: " sertifica ector,	Be	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec	k only one)			on's Home	
of Vi	Physi r this c eral dir	e: To	1 Inpatient 2 EF 27. Manner of Death 28a. Date of injury 28b.	3b. Time of	28c. Injury	4 ∐ Nursing Ho	ome 5 Resid			pre- pronac	
on (ending sath. or: Afte the fun	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	M 1 □	? Yes 2□No					
Division of Vital Records, P.O.	l or Att after de Directe	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowled 2 Medical Examiner: On the basis of examination a	nd/or invest	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.	
	To the within To the comple	Σ	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my 29b. Signature and title of certifler	knowledge,	29c. License			ne cause(s) and 29d. Date sign			
	(000		CA N	10	Dol	10380	メナー	(1)	271	10	
	JVI		30 Name and address of person who completed cause of death (Item 2:	3a) (Type, F LMU	Print) Che	sapea	Re Dr	Bel	air	-MD21014	
	Sta Registra		31. Date filed Mohth, Day, Year) 32. Registrar's Signatur	arker	,	1					

Ann Skriver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louis Stanley Seidel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SALISBUI Center HICOMICO TENINSULA If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours Director 218-20-9962 1 XM 2 - F 83 June 30, 1929 Marvland Usual Residence of Deced tal Hyglene. so other than "natural", or items 23a or 28a-f show event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖺 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 31011 Old Ocean City Road 21804 within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 x Married é 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5± Public Education Principal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mentai H 27 is marked or treumatic eve permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is market any injury or other treumatic a once. 9 Anna G. Silverstein Joseph (nmn) Seidel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin N. Seidel / Son 9512 Harbor Lights Drive, Berlin, MD 21811 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 11-30-2012 Bel Air, Maryland 21. Signatur of Funeral Syrvice Journey 22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each library Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requirss that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlai-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medicai Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 \square Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who compl use of death (Item 23a) (Type, Print) 0 6 21801 ENG MO 100 CATTOI

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

NOV 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 9:20 pM Leonore Kay Simmons 26. 2012 November 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Churchville 2925 Graftons Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Month Hours Min 173-28-7571 1 🗆 M 2 🔀 F Feb. 13, 1936 Pennsylvania Usual Residence of Deced 76 10c. City, Town or Location 10b County 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21028 2925 Graftons Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Leah Moser Leon Horace Harbold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Level Road, Churchville, MD 21028 Debra Grabowski / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion UMC Cem. 11-30-12 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Day Month Vear Pregnant at time of death 2 1No 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

Department of Health a Important: If item 27 is any injury or other trainonce.

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f show notified at

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items death v

ms 23a or must be

"natural", or item edical Examiner n

Director

Funeral

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Completed

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within 72 hours after

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by

IF FEMALE:

as for use signed by the at page 2 should filled in by the funeral director,

Be

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Certificate:

Medical

Physician: The law requires that the death certificate be

certificate has

After this

after death. Director: Af

within 24 hound to the Funer completely fi

Box 68760

Records, P.O.

Division of Vital

To the Hospital or Attending

9 Unknown

Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural

Date filed (Mo

30

vatural
2 Accident
3 Sui-5 Pending Investigation 6 Could not be 4 Homicide

28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 1 🗌 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28d. Describe how injury occurred 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 Residence 6 Other (Specify)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Other:

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) 27

30. Name and address of person ocompleted cause of death (Item 23a) (Type, Print)

32. Registrar's

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :50 PM Medical 4a. Facility Name County of Death not institution. **Examiner** 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Director 1 🗆 M 2 💢 1)04 irainia 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified 28a-f 1 Yes 2 No 10f. Zip Code ò 10g. Citizen of What Country? must be I items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 ρ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, To Be 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) and Mental F traumatic Informant's Name/Relationship (Type, Print) Jaugh-ler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat athi 20b. Place of Disposition (Name of 20a. Method of Diecosition Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21/2012 ature of Funeral Service Licensee 22. Name and Address of Facility assahn Funeral Home PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 🗌 No Yes 2 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) pletely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Myree Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar

NOV 3 0 2012

KATHERINE

21236

completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 29. GEORGE EDWARD THOMAS, JR. **201**2 9:32 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Center Timonium Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year 215-42-0196 **Director** 1 X M 2 □ F 70 Apr 18, 1942 Yrs Maryland Usual Residence of Decede or 28a-f shov 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Me ical Examiner must be notified at 10d. Inside City Limits Director Maryland N/A 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5755 Edge Park Road 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. mit. Page 1 and 2 should be filed within 72 hours after c eartment of Health and Mental Hygiene. cortaint if item 27 is marked other than "natural", or inluny or other traumatic event, the Me iteal Examin ğ 1 X Never Married 2 Married Maryland 21215-0036 f Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. 3 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Koppers Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Edward Thomas, Sr. Neva Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Garrett (Friend) 4 Brandon Court, Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dul Valley Men Grdns 12/4/2012 Timonium, Macyland permit.
Decarting onta any inju 21. Signatur of trutal Sandal Asses woon

Martin D. Lawson MINCHELL WIEDEFELD FUNERAL HOME INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and stransit Hospital or Attending Physician: The law requires that the death certificate be executed TROITN that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical ER 29, 201 Box **68760** IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number lune aa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV CRNP JUNECIA WHITE, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 012 Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death | OWSON |f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 1 □ M 2 M F ?? is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10a. State 10b Count 10c. City, Town or Location Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland 10d. Inside City Limits Funeral Director imore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 10 No 3 ₩idowed 4 Divorced If Yes. Give Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mentel Hygle Is merked other a 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/334 19a. Jnformant's Name/Relationship (Type, Print) nt of Health a t: If Item 27 is or other tre a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City ok Jown, Stat Depertment of H Importent: If Its eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 011 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Speast CANKEN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burlal-transit or Attending Physician: The lew requires that the deeth certificata be executed resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician, pege 2 should be deteched for use es the burla. Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitel or Attending Physician: Inelew within 24 hours after deeth.

To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) ဥ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) M.S. U Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 27 2012 Normber s of person who completed cause of death (Item 23a) (Type, Pript)

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Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Travis Tucker 7.55-PM nown her Je12 Medical ocation of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Town, or Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min (Month, Day, Year) Hours 579-18-2811 1 🖁 M 2 🗆 F Director 87 Dec. 13, 1924 Yrs. Washington, DC show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Virginia Rappahannock Castleton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 641 Laurel Mills Road 22716 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 3 Divorced 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Appraiser Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubert Quinton Tucker Mary Elizabeth Carpenter 19a. Informant's Name/Relationship (Type, Pr(npaughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia T. Sledjeski 6308 Herringdon Rd., The Plains, VA 20918 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burjar 2 🛱 Cremation 3 ☐ Removal from State cemetery, crematory or other place. Found & Sons 11/28/2012 Culpeper, VA 4 Donation Other (Specify) Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 ral Service Lio 21. Signature of Fun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Joseph Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for 4 ☐ Pregnant 9 ☐ Unknown Month Day Year Pregnant at time of death detached er at unrector; Attenthis certificate has been signed by filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA a er death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Z Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO056949 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Du Kawali Stee Boug MD 6620 (RAIN HOY, LA PLATA, HD - 20646 6 V

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Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robinson L walken Jr November 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimorp Hospital Northwest Rondallstown Social Security Number 419–24–0894 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Director 13√3M 2 □ F 87 Yrs. 1/24/25 ALUsual Residence of Decedent 1 and 2 should ba filed within 72 hours aftar daath with the Maryland of Health and Mantai Hygiana. itam 27 is marked other than "netural", or Items 23a or 28e-f show othar treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Directo MD Randallstown Baltimore 1 ☐ Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Robosson Road Funeral 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married چ Maryland 21215-0036 Black 1 ☐ Yes 2XX No Specify: If Yes, Give Completed 3 XXVidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CSX Railroad Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ethel Edwards Robinson Lee Walker, Sr. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 Meriam Ct., Owings Mills MD 211117 Shannon K. Harmon /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any Injury or of once. 1 Burial 2 Cremation 3 Removal from State 11/26/12 Toledo, OH Forest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility} CHarles L. Stevens Funeral Home, 1501 E. Fort Ave Baltimore MD 21 21. Signature of Funeral Service Licensee Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Bowel Physician/ 06struction Medical resulting in death) Due to (or as a consequence of): myocardral infarction Examiner Acute Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and usa as the buriai-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last signed by tha attending physiclan d be detachad for usa as the buria Physician/Medical The law raquiras that the death certificate ba Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Renal 1 Yes 2 No 3 Probably 4 Unknown Completed Aftar this cartificata has baan si funarai diractor, paga 2 shouid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗎 No To the Hospital or Attending Physician: within 24 hours aftar daath.

To the Funeral Diractor: Aftar this cartific complately filled in by the funaral diractor. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

31. Date filed (Month, Day, Year) NOV 3 0 2012

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29b. Signature and tip

Name and add ijunzhon

ss of person who completed cause of death (Item 23a) (Type, Print)

POBOX 7613 Salisbury 32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

November 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician P^{M} November 26, Rosa Webster 2012 9:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince GEorge Cherry Lane Nursing Center Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Jan 16, 1928 Germany 84 Director 215-44-2898 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10b. County and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Laurel Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 Main Street #214 20707 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: 2 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be to Department of Health and Mental Important: If item 27 is reany Injury or other. Be Magdalena Maier Franz Xaver Brandl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara W. Shiro /daughter 8312 Summit Hill, Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) W. Arundel Crematory: Nov 30, 12 Odenton, Maryland 21. Signature of Fuperal Survice Licens 22. Name and Address of Facility M Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, Maryland 20707-4389 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart slure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause Final Matasta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown been signed be should be deta Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Rescu 2□ No Pariphoral B1500.30 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was cas referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Oney Limige 4701 Rando/ph Pd # Z16. ROCKIS/(4, MD 20852)
31. Date filed (Month, Day, Year) --- 32. Desistrar's Signature --- MOV 3 0 2012 Show S. January

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Westler 0836 AM Novem 61 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death - medical Baltimore university of marylard Can . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215-88-8379 Hours Director 1 □ M 2 🗹 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director more 1 Ves 2 No Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kipd of work opne during most of working life. DO NOT use refered)

Senetit Huthor; Zer 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, စ္ M:Iliams 19a. Informant's Name/Relationship (Type, Print Caltimore oad 20b. Place of Disposition (Name of cemetery, grentatory of other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ida ikesvi Signature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Preumonia and Death Physician disease or condition resulting in death) 6 days Medical Due to (or as a consequence of): Examiner 5+0+0 omonth Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Bedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Bedical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) CRNP 1740489970 pleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of

31. Date filed (M

Street,

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep	artment of Health and Natificate of Death		_ 2111 / 31	3652				
			Registrar 1. Decedent's Name (First, Middle, Last)	initiate or boarn	2. Date of Death		e of Death				
	Physicia Medic		John Elwood Ward		Month November	Day Year 27. 2012 1:	35 p ^M				
and a	Examin		4a. Facility Name (if not institution, give street and number) 4010 Forest School Road	4b. City, Town, or Location of Death Smithsburg	4c. County of Death Frederick	-					
	Funeral Director		5. Social Security Number 213–40–7815 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 69 Yrs.	9. Birthplace (Sta 943 Mary Land							
	and show f at	jo.	10a. State 10b. County 10c. City, Town or L	ocation		10d. Insid	le City Limits				
	Maryli 28a-f otifiec	irect	MD Frederick Smithsbur	g		1 🗆	Yes 2 🔀 No				
	th the	Funeral Director	10e. Street and Number 4010 Forest School Road	10f. Zip Code 21783	10g US	g. Citizen of What Country? ⋜ ∆					
	ath wi	nue		Was Decedent of Hispanic Origin? (Spo	14. Race - American Indian	Race - American Indian					
920	s after de ral", or ite Examine	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ ★Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 😿 No Specify:	Rican, etc.)	Black, White, etc. Specify: White					
2-0	2 hour "natu edical	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business/Industry					
121	ithin 7 ene. • than the Me	Completed	Elementary/Secondary (U-12) College (1-4 or 5+)	oo NOT use retired) ard Foreman	I	Agriculture					
d 2	iled will Hygi	Be	10 OLCI 17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Surname)					
ylar	id be f Menta arked atic ev	입	Lester Ward	Margaret	Howard						
, Maryland 21215-0036	and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship (Type, Print)19b. MaiWanda Barton/daughter2971	ing Address (Street and Number or Run Greensburg Road M	al Route Number, Ci Yartinsbu	ty or Town, State, Zip Code)					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	osition (Name of ematory or other place) erney Crematory 11,		oc. Location - City or Town, State	e				
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee MO1251 H	2. Name and Address of Facility Oing Home Crematic Severly L. Heckrot	on Service	e P.O. Box 784 Clarksville, MI	21029				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			, Approxi	imate Between				
	Medical			NPARLTION		Unset a	and Death				
-	Examiner		Due to (or as a consequence of).	TIL CARDIOVASCUL	ME DIS	ense yen	R.J				
	عوو	iner	if any, leading to immediate Due to (or as a consequence of):								
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events c. FREVIOUS STA	IKE		Yen	HCA				
09	ite be executed hysician and the burial-transi	dical		LUTUS		Yen	HLS				
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	Year				
s, P.O.	ires that th signed by I'd be detact	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause	of death?				
Division of Vital Records,	ne law require e has been si age 2 should	Completed			24a. Was an autopsy performe		of cause of				
al H	ifcian: The certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Death (Chec		A NOT TELES 2 INC					
ξ	Physic this ce ral dire	욘	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			ce 6 Other (Specify)					
n of	ding F h. After 1 funer	ate:	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how	injury occurred					
ivisio	after deat after deat Director:	Certificate:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route N State)	lumber,				
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invo	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year	r)				
	(MA		Medu Ms.	946561		11.28.2012					
_	2/10				AGONTONO	N MD 217	40				
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 2012 32. Registrar's lignature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 20 k Month Physician/ November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Aronde Baltimore washingtonnedical Center 6len Burnie If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months (Month, Day, Year) 214-38-7222 Director 1 □ M 2 🗓 F WV 08/06/1940 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 2 No Laurel Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9000 Briarcroft Lane Apt. 302 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 22 XNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ဩtNo Specify. Specify. Completed 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tool Crib Attendant Machine Shop 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry McMillion Mable Caves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 Ms. Darla Stanley / daughter Millersville, Maryland 543 Donner Way, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/01/2012 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv Brooklyn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Glen Burnie, MD 2nd Ave, SW M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) hours Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompletely filled in by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes patient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gretifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and at person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Gladvs M. Allen November 8:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 915 Winding Way Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 102-30-2009 1 □ M 2 🗓 F 89 10/03/1923 India Usual Residence of Deced permit. Page 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23e or 28e-f showery injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 915 Winding Way 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Doctor/Public Health Of: (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Health Officer Public Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Walter Kendall Allen Beulah Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford P. Cooper/Nephew 4626 Cooper Rd., Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 11/16/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 of Funeral Service Licensee Hompron (FSt) 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events To the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗖 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy After this certificate funeral director, pag Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) 2 🖾 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After Natural injury 5 Pending within 24 hours after death

To the Funeral Director: A

completely filled in by the f Accident Suicide Investigation 3 🗆 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Nu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jeffrey Adkins Wayne 8540 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Medical KIGOMICO Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 212-88-1176 1 🗓 M 2 🗆 F 47 07/26/1965 Maryland ou ourer man "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Fruitland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Olde Field Court 21826 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married <u>۾</u> 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Construction Be Page 1 and 2 should ba filed in ment of Health and Mantal Hygant: if item 27 is merked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jane L. Shirey William G. Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, of Health (100 Olde Field Court, Fruitland, MD 21826 Vicki R. Adkins/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/7/2012 Salisbury Crematory Salisbury, MD 21804 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Rd Salisbury, MD 21804 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Enysician/ BRAIN TUMOUR. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signad by the attanding physician and d ba datachad for use as the burial-transit The law requiras that the daath cartificata be executed Cause (Disease or injury COPD that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, cate has baen si Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Aftar this cartificate Yes 2 WN Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ရု 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division death. within 24 hours aftar death

To the Funerei Director: A

complataly filled in by tha f 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of D-71972 IMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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disease or condition resulting in death)

only one) 29b. Signature and title of certifier

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:45 P M ANNA MAE ANTONE OCTOBER 28, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN CHESTER RIVER MANOR KENT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 07/21/1919 93^{Yrs.} MARYLAND 215-20-0770 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MARYLAND KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 MORGNEC ROAD APT #302 UNITED STATES 21620 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DAY CARE PROVIDER CHILD CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES W. BECK BLANCHE FRAZIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID ANTONE / SON 11897 STILL POND ROAD WORTON, MARYLAND 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State WESLEY CHAPEL CEMETERY 11/10/12 ROCK HALL, MALRYLAND 4 Donation 5 Other (Specify) 21. Signature of Faneral Service Licenses FELLOWS Addreed Fenbein & Newnam Funeral Home. 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or police shock, or heart failure. List only or atio's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Interval Between Onset and Death Immediate Cause (Final mantion advanced Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 9 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No

Physician/Medical Completed by Be ည Certificate:

this nours after death.

neral Director: After the filled in by the funeral

To the Hospital or Att within 24 hours after do To the Funeral Direct State Registrar IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1) Chronic Atriel Fibrillation & Hyperetinsion D'Unonic Renal Insufficienzy Shreene 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D21313

11/2/12

Washington Ave, Chestertown, MD 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV - 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

415

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ammend Box 8 Per FH WSH Carroll Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Catherine 9:45 am Armacost NOV 2017 /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Deeth 4a. Facility Name (If not institution, give street end number) Examiner Baltimore 2802 Pinewood Ave Esther's Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8/28/37 (Month, Day, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🖫 F 75 MD Director 213-36-7933 8/24/1937 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other then "netural", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Upperco 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 17634 Bruehl Road 21155 Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. e filed within 72 hours efter d il Hygiene. other then "netural", or item 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white Specify: ğ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker/farmer own home permit. Pages 1 end 2 should be filed v Depertment of Heelth end Mental Hygie Important: If item 27 is marked other i eny Injury or other treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Krout Benjamin Ensor 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 17634 Bruehl Road, Upperco, MD 21155 C. Austin Armacost, husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 11/7/12 Hasmpstead, MD 22. Name end Address of Facility Eline Funeral Home 21. Signature of Funerel Service Licensee M00741 934 S. Main St., Hampstead, MD 21074 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Dementia 10 YEAVS Examiner Physician/Medical Examiner signed by the ettending physicien end d be deteched for use es the bunel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 thet initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Chronic Obstructive Palmonery 1 ☐ Yee 2 ☐ No 3 ☑ Probably 4 ☐ Unknown <u>ک</u> should be 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Tes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) Assisted Living Certification: To 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Tes 2 🗆 No death. investigation rerel Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours ef To the Funerel Di 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 1757444 November 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

PU BUX 19099. TOWSOM,

21284

State Registrar Chen

32. Registrar's Signature

Deneur

12-08315 Elizabeth Apple Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 3, 2012 0650 hrs **Medical Examiner** Elizabeth C. Apple 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Worcester Atlantic General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Country) MD Months Hours Director 215-48-7028 60 8-10-1952 1___M 2 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No 28a-f show MD Worcester Berlin hours after death with the Maryland rector 10f. Zip Code 10g. Citizen of What Country? s 23a or 28a-f e notified at o 10e. Street and Number 11702 Bay Landing Drive 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funera 11. Marital Status 12. Was Decedent Ever in U.S. or items White, etc. Armed Forces? 1 Never Married 2 Married Yes White Specify: 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year marked other than "natural", Þ or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 6 Teaching Worcester County and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Malcom Washington Gray Mary Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Richard Apple-Spouse 11702 Bay Landing Drive, Berlin, MD. 21811 des it of Health a at: If item 2' 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11-5-201 Millsboro, De. State Crem. First 4 Donation 5 Other Specify: 22. Name and Address of Facility The Burbage Funeral Home Street, Berlin, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Wedical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate caus. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical UNPENDED AMENDED the attending physician ned for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth Year 3 Ectopic pregnancy Month 2 Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pendina · death. Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) To the Hospital o within 24 hours af To the Funeral D (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day Year) November 4, 2012 O.C.M.E. and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZOIZ Month Physician/ Abell, Jr. Joy 5010A M Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Lanham Doctor's Community Hospital Prince George's . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 89 214-22-6016 Director 1 X M 2 □ F 8/11/1923 Maryland 3a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Prince George's Glenn Dale Marvland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral U. S. A. 6215 Bell Station Road 20769-9142 Examiner must items ; 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married "natural", or by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Marylan'd 21215-0036 1 ☐ Yes 2 X No Specify White 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea proces. United States Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Catherine Louise Woodburn Joy Abell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6215 Bell Station Road, Glenn Dale, Maryland 20769 Edna Abell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 11/5/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee Fres 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami Cause (Disease or injury the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 🗌 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 U No Certificate: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide 1 Tyes 2 \square No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of control 170102 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 8118 Good huck Rd., Casham, MD. 20706 n No Zama MD . 31. Date filed (Month, Day, Year) State NOV 08 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Nov. 2012 Shirley Ermine Alexis 12:30p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X X Months Hours Min. 0ct. 30,1952 60 None Grenada **Director** Usual Residence of Decedent 28a-f shov 10a, State 10d. Inside City Limits with the Maryland must be notified at 10c, City, Town or Location Director Upper Marlboro MD Prince George's 1 Yes 2XX No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 309 Bishops Hall Court 20774 Grenada items 2 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Care Giver Children/Elderly Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Boopsingh Ilis Alexis Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Alexis/Son 309 Bishops Hall Ct.Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ξ 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Nov.10,2012 Baltimore, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician. tscending Medical resulting in death) to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exam burial-transit and Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Pregnant at time of death the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ျှ 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify . Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director, After tl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident filled in by the Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b Signat

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

antiago A. Lopez	1	State legistrar	ate of Maryland		ent of Headar ate of Dea		Re	g. No. 2012	3366
Physician ledical Examine	1	1. Decedent's Name (First, Middle Santiago	e,Last) Lopez	An	geles		2. Date of Death Month October 31	Day Year	3. Time of Death 1310 hrs
icarcar Examina		4a. Facility Name (if not institution	n, give street and number)		4b. City	, Town, or Location of Deat		4c. County of Death	
Funeral Director		1640 Homewood Road	6. Sex 7. Ag	e (In yrs. last bi	rthday) If U	napolis nder 1 Year If Under 24H nths Days Hours Mi		h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or more)
Birector	-	none Usual Residence of Decedent	1 X M 2 F	50	Yrs.		1/25/	7 1902 00	
faryland 28a-f show any 1 at once.		MD 10b. County Anne	Arundel	10c. City, Town	apolis				10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once		10e. Street and Number 1013 Bay Wir	nd Drive			Zip Code 21401		Mexico	
	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Div	arried 12. Was Decedent Armed Forces? 1 Yes 2 orced If Yes, Give Year or Dates:	X No	If Yes, spe	2 No specify:	ican, etc.)	White, etc. <i>[v]</i> Specify:	ican Indian, Black, 7hite
hin 72 hours a team "natura edical Exami	Completed to	15. Decedent's Education (Spec Elementary/Secondary (0-12)			during most of	IAI Occupation (Give kind of working life. DO NOT use re Cape Workes	etired)	16b. Kind of Business/ Landsca	-
21215-0036 sulo be filed within 72 hor Normal Hygiene. marked other than "mar te event, the Medical Ex-		9 17. Father's Name (First, Middle, Juan Lopez					ne (First, Middle, M		
MD 21, ad 2 should be ulth and Men ulth and Men an 27 is mar	2 [19a. Informant's Name/Relations Miguel Angel	hip (Type, Print) soil Lopez Goi	nzalez	1013	ess (Street and Number of Bay Wind Di	cive Anı	napolis,M	d.21401
More Pages 1: ent of H unt: If in		20a. Method of Disposition 1 Burial 2 Cremation 4 Docation 5 Other Sa 21. Sign are of Funeral Service	perify!	ate Ceme	tory or other pla terio i titucio	on Mexicana	l	Oaxaca,M	
Balti per t. Degarri	-	tally 11 M	ant		19241	ndAddress of Farily IP D.RINALI Columbia I	Blvd.Si.	lver Spri	ng,Md20910
Physician Wedica		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		not enter the mod	de of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death:
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of):					
		events resulting in death) Last	Due to (or as a consid.	equence of):					
0, be executed vician and burial - transit	edical	UNPENDED	AMENDED	11					
	š١	IF FEMALE: (3b) Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	I TIVE DILLI	me of pregnanc	y 2 Fetal dea 5 Other (S		nancy	23d. Date of deliver Month	y Day Year
res that the designed by the		Part II. Other significant condit	tions contributing to deat	h but not resulti	ng in the underly	ring cause given in Part I.		bacco use contribute to	
ords aw requirements been a 2 should	Completed by						24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medica examiner?	Maria Mala	ent 2 ER/	Outpatient 3	26 Place of Death (Chec		Residence 6 ✔ Othe	r: Scene
on of Vi ending Physi ath. or: After this he funeral dir	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Injudent Day Oct 31, 2012	ury 28b	Time of Injury	28c. Injury at Work?	28d. Describe to Tree fell on	now injury occurred subject	
Division of No the Hospital or Attending Physical or Attending Physical Structure and To the Funeral Director. After to the Funeral Director. After the Completely filled in by the funeral Director.	Certification:	3 Suicide 6 Cou	stigation Id not be ermined (Specify) Ya		farm, street, fac	ory, office building, etc.	or Town, S		ural Route Number, City
To the Host within 24 ho To the Functional Completely forms	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of maminer: On the basis of exa and manner stated.	ny knowledge, d imination and/o	eath occurred at r investigation, ir	the time, date and place, and my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as sta and place, and due to t	ted. ne cause(s)
Tour Tour Tour	Me	296. Signature and title of certific	er Cours)			29c. License number O.C.M.E.		29d. Date signed (Mo November 1, 20	
		30 Name and address of person Laron Locke MD. A	n who completed cause of a Assistant Medical Ex			ore Street, Baltimore	, MD 21223		
Sta Registra		31. Date filed (Month, Day, Year)	2012 32 Registra	ar's Signature	harted				
DHMH 17 Rev 1/200	_		10	0	RIGINAL				

Physician Medical Examiner

Department of h Important: If its any injury or ot once.

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a

1 and 2 sof Health

notified at

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner attending physician and a for use as the burial-transit by Completed Be Certificate: To To the Hospital or Attending F within 24 hours after death. To the Funeral Director, After filled in by the

Medical

23b.

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	U CT	Kstons		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No g ☐ Unknown	Bc. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions con Kidney Disease	prouting to death but not less	sulting in the underlying	g cause given in Part I.		
25. Was case referred to medical			26. Place of Death (Che		100
examiner?	ospital:	ER/Outpatient 3 🗆	Other:	Home 5 Residence	e 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
(Check 2 Medical Examine	cian: To the best of my knower: On the basis of examination Practitioner: To the best of	n and/or investigation,	in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s) and manner stated.

0 18101 Prince Phillip Drive

Olney, MD 20832

State

Registrar

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			State Registrar		,	Certifica	te of D	eath	,	Reg. N	2 U	12	385	000
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)				-	2. Date of De	eath)ay	Year	3. Time of I	Death
	Medic			Godwin Baz	emore,	Sr.			10	28	3 20	012	4:07	РМ
	Examin	er	4a. Facility Name (if not institution	,				Location of Death		4	c. County	of Death		
			l Jonesvil					sville	T :		10nt		ry Co	
I	Funeral Director		5. Social Security Number 241-32-6511	6. Sex 1 M 2 D F	ge (In yrs. last bi 85	Yrs. Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth y, Year I — I	27	9. Birthp Coun NO •	place (State or carol	Foreign ina
	how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Toy	vn or Location							10d. Inside City	v Limits
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21215-0036	ural", or i I Examín	Completed by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates.	No No		2 XNo		Hican, etc.)		Specify:	k, White, 6 B1	etc. ack	
5-("nat	ble		nt's Education st grade completed)	16	a. Decedent's Us (Give kind of w	ork done du	tion Iring most of worl	king	16b.	Kind of Bu	usiness Inc	dustry	
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d 2	ed wi Hygie other	Be	3 17. Father's Name (First, Middle, L	ast)		FO	remar	18. Mother's Nan	no (Eiret Middle				1011 00	
Maryland	be fill ental ked c	힏	Eugene Bazer						e Haro		1 Surriarrie	,		
3	nd M		19a. Informant's Name/Relationsh		19	b. Mailing Addre	ss (Street ar	nd Number or Rui	al Boute Numb	er City o	or Town. S	tate Zio (Code)	
	d2stalthaaltha27is		Karin Bazemon	re (Daught		_		e Ct.,					2083	37
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (S	3 Removal from State	20b. Place	of Disposition (Na ery, crematory or PM EM	other place	ark IIII	Date 0/2012	20c.	Location	City or To	own, State	,
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service I		— t per 1/20			lifiams, ncetons				<u>_</u>		
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	Physician/ Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Non S	Small (Cell Lu	ng C	ancer					Interval Betw Onset and D	veen
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0	e be e ysicia e bur	lical		d										
8760	as if	Medical Examiner	IF FEMALE:											
9	ath cert attendir for use	-	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2 Fetal dea	th 3 🗆 Ectopic	pregnancy					te of delive	•	
Вох	deat he at ied fo	Physician,	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (specify)				Mo	ath	Day Ye	'ear
P.O.	that the de red by the detached		Part II. Other significant condition	ns contributing to death l	out not resulting	in the underlying	ı cause give	n in Part I	23e Did t	obacco	use contr	ibuta to th	he cause of de	ath?
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Ä	ician: The la certificate ha ector, page		Hypertension 25. Was case referred to medical						perfe 1 Yes	2 🔼	No 1	I ☐ Yes	2 🗆 No	
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of V	Phys r this eral di	<u>은</u>	27. Manner of Death	28a. Date of inju	ıry 28b.	Outpatient 3 🔲 [Time of	28c. Injury a	4 Nursing H	ome 5 LXResi 28d. Describe					
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Division	I or Attendii after death. Director: Ai I in by the fu	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inj	ury - At home, f	arm, street, facto	ry, office		28f. Location (r or Rural	Route Numbe	∋ <i>r</i> ,
Dί	tal or A rs after al Direct ed in by	<u></u>			c. (Specify)				City or To	vn, Stat	e)			
	To the Hospital or a within 24 hours after to the Funeral Dire completed filled in L	Medical	29a. Certifier 1. Certifying (Check 2 Medical E	Physician: To the best of xaminer: On the basis of e	f my knowledge	, death occured a	at the time, on my opinion	date and place, a	nd due to the ca	ause(s) a	and manne	er as state	d. use(s) and man	ner stated
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			30 Name and address of person of the Kalw	1396	Piccare	a Di	r. Koc	Kvill	er	MD	120	085	8	
4	Stat Registra	<i>10</i>	31. Pole filed (Month, Day, Year)	2012 Lesen	ar's Signature	garke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38664 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 Alice Lorraine Barnes 5:45 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Hours **Director** 220-07-1422 1 . M 2 X F 90 Sept. 29,1922 Maryland Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c City Town or Location Director MDDorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4364 Egypt Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) piece worker garment should be filed with and Mental Hygien is marked other th 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John A. Busta Lillian Spear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. daughter Merry L. Webb 4364 Egypt Road, Cambridge, MD 21613 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 11/6/12 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral So 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between direck Immediate Cause (Final Onset and Death Physician/ Carto valenta Arterioscloronc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the at d be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? within 24 hours after death.

To the Funeral Director, After this certificate be completely filled in by the funeral director, pagn 2 40 2 4 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica To Be 26. Place of Death (Check only one) Other: 1 Yes 2 9 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractifioner: To the best of my knowledge. death perumid at the time, date and plans 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

503

32. Registrar's Signature

NOMAN TITATIONY

31. Date filed (Month, Day, Year)

D47924

CAMBRIDGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner INC Queen Annes entreville Anne een 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 MM 2 DF Director Usual Residence of Decedent and Mental Hygiene.
and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shot is marked other than "natural", or items 23a or 28a-f shot is marked other than Medical Examiner must be notified at or items 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No 40 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Mer 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) perat injury or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 601 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, ci Bethel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any une 10.21613 lashing to Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alcoholic Curhosis LIVER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year 2 No within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ٩ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTREVILLE 21617 JEFFREY L. UKENS 2540 CENTREV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LUCILLE HARPER BRADSHAW 155 ctob. Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Cente ALNINSULA NICOMICO RIGIONAL SAL156414 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 225-28-1650 Director 1 🗆 M 2 🛛 F Nov. 4, 1926 North Carolina 85 1 end 2 should be filed within 72 hours effer death with the Maryland of Heelth end Mentel Hygiene. If them 27 is merked other then "neture!", or items 23e or 28e-f show other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Hebron 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>7328 Levin Dashiell Road</u> 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Black, White, etc. <u>ک</u> Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Manager Shoe Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Harper Penny Agnes Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dennis Rollins Bradshaw</u> -26821 Robert Burns Lane - Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Depertment of Important: If it eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Mem. Park Nov. 5, 2012 Crisfield, Maryland 21. Signature of Funeral Service Licenspe

Mary Beth Bradshaw-Pruj 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) CARDIOVASCULAR Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of history) Due to (or as a consequence of): Examir ettending physicien end I for use es the burlal-trensIt or Attending Physicien: The lew requires that the deeth certificete be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year ed by the e 9 Unknown 9 Unknown P.O. been signed by t should be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Records, ARTHRITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Rheumatoid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s burs after death.

erei Director: After this certificete hes filled in by the funeral director, page 2 perform 1 Yes 2 No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner's Hospital: Other: 4 \(\text{\text{Nursing Home}} \) 5 \(\text{\text{Residence}} \) Residence 6 \(\text{\text{\text{Other}}} \) Other (Specify) 2 X No 1 Yes မြ 1 Inpatient 2 D ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitei of within 24 hours at To the Funerei D completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D36576

State Registrar

DHMH 17 Rev 06-2011

B. par

1665 WOODBROOK DR

SALISBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRAVITE MD

32. Registrar's Signature

P

KONALD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H tificate of D			liene leg. No. 201	2 38667
	Physicia	n/	Decedent's Name (First, Middle, Last					Date of Deat Month	th	3. Time of Death
	Medic	al	Bernard 4a. Facility Name (if not institution, give	Street and number	•	Butler	Location of Death	Novembe		
	Examin	er	100 Overlook Driv			Salisbu			Wicomio	
	Funeral Director		5. Social Security Number 6. S 150–16–7674		(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-23-19	9	o. Birthplace (State or Foreign Country) New York
	nd how at	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla :8a-f s vtified	rect	MD Wicom	ico	Salis	sbury				1 ☐ Yes 2 💹 No
	h the la or 2 be no	al Di	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wit	Funeral Director	100 Overlook Driv	re, Apartme	er in U.S. 13. V	Nas Decedent of Hi	1804 spanic Origin? (Sp	ecify Yes or No-	USA 14 Bace -	American Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	0 1	f Yes, specify Cubai 1 ☐ Yes 2 🎇 No	n, Mexican, Puerto	Rican, etc.)		White, etc. White
2-0	2 hour "natu	Completed	15. Decedent's E (Specify only highest gr		(Give I	dent's Usual Occupa	ation Juring most of work	ring	16b. Kind of Busin	ness Industry
12	ithin 7 ene. r than	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)) life. Do	O NOT use retired) Bus Driv	er		Transp	ortation
<u>م</u>	filed wall Hygi I other vent, i	B B	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, N	Maiden Surname)	
ylaı	uld be Menta narked natic e	욘		ernard	Butle		Irene			Donahue
Mar	2 shouth and the and the street the traum.		19a. Informant's Name/Relationship (7) Rosemary Butler			3		· ·		isbury, MD
ē,	1 and of Heal item (20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - Ci	
<u>i</u>	Page ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Mt. Carme			12-2012	Tenafly	, New Jersey
Baltimore, Maryland 21215-0036	permit. Depart Import any inj	2 0	21. Signature of Funeral Service Licen	uy Bla	10	2. Name and Addres			neral Hor ry, MD 21	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	ications that caused to one cause on each line.				or respiratory arre	est,	Approximate Interval Between Onset and Death
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	Examiner			Due to (or as a	consequence oi).					
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	_				
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876	tificate ng phy as the	Medi	IF FEMALE:					_		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 1 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date o Month	
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	To the within To the comp	2	29b. Signature and title of certifier	1	, ,	29c. License		- 1	29d. Date signed (//	
	M			m		Di	1094		11/9/12	
	1010		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F	Print) Mf He	nucy	Road	SALISAC	my m 21804
	Sta Registr		31. Date filed (Month, Day, Year)	012 32. Fegistrar	's Signature	MANGE				

12-08257 Grace M Baier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ace M Baier		1- For State Registrar	State	of Maryl	and / D	•	irtment d tificate d			and	Menta	al Hy		Reg. No	. 20	12	3866
Physicia edical Exami		Decedent's Name (First, N										2	2. Date of De Month October 3		Year		3. Time of Death 2240 hrs
		Grace McDona 4a. Facility Name (if not insti	ution, giv	e street and n	umber)						ocation of	Death	October .	4	4c. County of		
F		Meritus Medical Ce 5. Social Security Number	nter 6. Se		7 Age (In	vre la	ast birthday)	_	lagerst		If Under	24Hre	la Date of B		Washingt		nplace (State or
Funeral Director		207–18–1640		M 2XF	7. Age (ii	86	Yı	T	Months	Days	Hours	Min.	10/15			oreigi	ntry) PA
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2	Married	12. Was De Armed F	orces?								cify Yes or N lican, etc.)	0-	14. Race - White,		an Indian, Black,
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hours :	ed b	15. Decedent's Education (nly highest gra		ted)	16a. Decede during r				n (Give kir O NOT u			16b.	Kind of Busi	ness/Ir	adustry
136 thin 72 ne. than '	Completed	Elementary/Secondary (0-	12)	College (1-4 or 5+)		Homer	ak	er						Own Hon	ne	
21215-0036 uld be filed within 72 hours afte Mental Pygiene. marked other than "natural", c event, the Medical Examiner		17. Father's Name (First, Mic								- 1		•	First, Middle,				
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and 2 shoul lealth and N tem 27 is m traumatic		Grace Green/	Daug	hter													and 20878
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Balti permit. Departr Import injury		K. Bolye	rol	//	MO164	16	10	6	E. C	hur	ch S	Kee t.,	ney & Freder	Bas ick	sford E t, MD 2	Tune 2170	eral Home)1
Physician /Medical		23a. Part I. Enter the dist ase failure. List only one ca			caused the	death.	Do not enter	he n	node of d	ying, su	ich as car	diac or r	espiratory ar	rest, sh	ock, or heart		Approximate Interval Between Onset and
Examiner	Ī	Immediate Cause (Final dise or condition resulting in deat	, -	Acute Sub						<u>.</u>							Death
		Sequentially list conditions,	ь. <u>I</u>	Fall													
	mine	if any, leading to immediate cause. Enter Underlying Car (Disease or injury that initiate	ise	Due to (or as	a conseque	ence of):										
ansit	S	events resulting in death) Last Due to (or as a consequence of):															
o, e be executed ysician and burial - transit	edical	UNPENDED		AMENDED													
3760 ificate b	Σ	IF FEMALE: 23b. Was decedent pregnant	n the	23c. If yes,		f pregn	_	atal c	leath	3	Ectopic p	regnand	ev.	23	3d. Date of de	livery	av Year
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the Hospital		29a. Certifier 1 Certifyin		an: To the be	st of my kno	owledg	e, death occu	rred									
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19		Melissa Brassell, M 31. Date filed (Month, Day, Ye		sistant Me	edical Ex					e Stre	et, Bal	timore	, MD 2122	23			
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DHMH 17 Rev 1/2001

OCAME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 5, 2012 Anthony Joseph Barry 11:48 am Michael Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 218-27-5642 Director fxfxm 2 □ F Maryland Jan 18, 1990 22 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturo" ery hiury or other traumatic events. 10d. Inside City Limits 10b County 10c. City, Town or Location Funeral Director 1 Yes 2 No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 312 Greengate Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George T. Barry III Joanne Hachmeister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M/M George T. Barry III/parents 372 Vita Dr. Wheeling, IL 60090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XI Burial 2 Cremation 3 Removal from State St. Patrick Cemetery 11/8/2012 Little Orleans, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of cholecustecim complications Physician/ disease or condition -Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to invinediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificete be executed physician and s the burlal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 1 Yes 2 L 9 Unknown been signed by the a should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in/Part 23e. Did tobacco use contribute to the cause of death? Completed by naus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 autopsy 2 🗆 No 1 Tyes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔲 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury 28c. Injury at 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Director: And in by the f hours after death Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in I within 24 hours a To the Funerel Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated SC

State Registrar

8

701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

* READS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#23aIIperMD, 11/5/12; BWW, McCo Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death Physician/ Emerson Hugo Ballou, Jr. 10/30/2012 12:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring <u> Holy Cross Hospital</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 81 Director 579-36-4356 1 **X** M 2 □ F Yrs 1/15/1931 Pennsylvania Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 602 Ray Drive 20910 USA 12. Was Decedent Ever in U Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Ukn 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 Divorced "natural" Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Statistician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emerson Hugo Ballou, Sr. Phoebe Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11825 Maren CT., Reisterstown, MD 21136 Emerson Hugo Ballou, III 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 11/7/2012 Laurel, MD Maryland National 21. Signature of Funeral Service Licensed 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., NW, Washington, DC 2012 23a. Part 1. Enter the disease, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Days Respiratory Failure Medical Due to (or as a consequence of) Examiner <u>Pneumonia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ed by the a detached f ☐ Yes 2 ☐ ☐ Unknown signed t d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Subdural hemorrhage - Non-Traumatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 Tyes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: ည 1 🗌 Yes 2 X No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural Within 24 hours are:

To the Funeral Director: After

To the Funeral Director: After

To the Funeral Director: After

To the Funeral F 5 Pending 1 Tyes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check that the time Cartifying Nurse Practitioner: To the best of my knowle 29d. Date signed (Month, Day, Year)

State

Suresh K. Gupta,

31. Date filed (Month, Day, Year)

D)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-32332

10/31/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

avid Chalk		1- For State	ate of Maryl			nent of cate of			Menta	al Hyg		g. No. 20	112 3867	
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd	_{lle,Last)} vid Chalk								Date of Death Month November	1	3. Time of Death 1135 hrs	
		4a. Facility Name (if not institution 401 E. 25th Street		umber)		41	o. City, To Baltim		ocation of			4c. County of	Death None	
Funeral Director		5. Social Security Number 217 68 3319	6. Sex	7. Age (In yrs. 53	last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.						8. Date of Birtl 02/05	Birthplace (State or Foreign Country)		
Maryland 28a-f show any 1 at once,	o.	Usual Residence of Decedent 10a. State 10b. County MD None				n or Location	on						10d. Inside City Limits 1 X Yes 2 No	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 401 E. 25th St	reet		10f. Zip Code 21218						10	10g. Citizen of What Country? United States		
P 5 E	by Funeral	11. Marital Status 1 Never Married 2 N	12. Was De	2 🔀 No	If Yes, spe			Cuban, I	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.) No specify:					
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MD 2 nd 2 should alth and M m 27 is m aumatic e	٩	19a. Informant's Name/Relations Martha McSorle 20a. Method of Disposition		Log			Herm	tage	e Dri	ve I	Ellicot	t City,	MD 21042 City or Town, State	
Baltimore, MD 21215-(10 permit Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me		1 Burial 2 Crematio 4 Donation 5 Other S	pecify:	from State	crema	atory or other ation	er place) Cnti	of	MD	11-2	Date 27 – 2012	Hanove	er, MD	
		21. Signature of Funeral Service	s- With			41	12 0	ld Co	olumb	oia I	Pike El	licott (Family FH Inc. City, MD 21043	
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	Ja	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b	a consequence										
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1														
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2		30. Name and address of person Carol H. Allan, MD	n who completed cau Assistant Medi	,		,	altimor	e Stree	et, Baltir	nore,	MD 21223			
St Regist	ate	31. Date filed (Month, Day Year	7 2012 32. R	Registrar's Signa	ature	1 6	m. 10° 1	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Day Sarah Adline Curtis 2012 1600 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehab & Nursing Ctr Wicomico Salisbury If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Hours Director 242-34-2330 1 □ M 2**X** F 94 3-13-1918 North Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1101 Mineola Avenue 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced Specify Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Farming Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Parker Estella Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Atkinson/Daughter 503 Woodlyn St, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11-12-2012 Hebron, MD Gard ina 22. Name and Address of Facility 917 W. Isakella St. Bennie Smith Salisbury, MD 21801 21. Sign Jure | f Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 NO 1 🗌 Yes Other: |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral c 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; Completely filled in by the 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu License numbe 3TC ne and address of person who completed cause of death (Item 23a) (Type, Print) 1 Choluc egistrar's Signatur 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ November 8:40 P 2012 Dennis Cannon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Months Days Hours Director 222-16-6126 1 □ M 2 🗓 F 87 5-8-1925 Maryland Usual Residence of Deceden : if item 27 is marked other then "netural", or items 23a or 28e-f ehov or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 end 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Somerset Eden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14517 Benjamin Street 21822 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other then " Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ٥ Campbell Dennard Gladvs of Health and Nitem 27 Is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flora Vickers - Daughter 14517 Benjamin Street, Eden, Maryland 21822 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition permit, Page 1
Department of I
Importent: If it
eny Injury or o ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 11-9-2012 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home . Signature of Fune al Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or composications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List opt one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificete be executed signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 🗆 Yes 2 🖸 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be o Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Ū No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR, SALLBURY, MD

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2012 November Crogan, Howard Guy Medical 4a. Facility Name (if not institution, give street and number 4b, City, Town, or Location of Death Examiner 4c. County of Death 7507 Mountain Approach Road Adamstown Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8, Date of Birth **Funeral** Months Hours (Month, Day, Year) **Director** 213-72-2661 1 🕱 M 2 🗆 F 56 Aug. 25, 1956 West Virginia Usual Residence of Deceden or 28a-f show notified at 10b, County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏌 No Maryland Frederick Adamstown 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 7507 Mountain Approach Road 21710 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 I and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Purchasing Manager Rental Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard G. Crogan, Sr. Mary Lea Patterson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a: If item 27 is 21710 Janice Crogan - Wife 7507 Mountain Approach Road, Adamstown, Md. other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or Department Important: Il any injury or once. Darnestown Presby. Cem 11/09/12 4 ☐ Donation 5 ☐ Other (Specify) Darnestown, Maryland 22 Name and Address of Facility Molesworth-Williams P.A., Fu 26401 Ridge Road, Damascus, uneral Service Licer 21, Signature Funeral Home 20872 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events Due to (or as a cor resulting in death) Last physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b, Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 2 a No the g Unknown þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy HUPGRLIPA NEW IK performed' 2 No Yes 2X No 1 🗌 Yes 25. Was case referred to 26. Place of Death (Check only one) Be Hospita Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) 1 Yes 2 X မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending XNatural 5 Pending alural
Accident
Suicid 1 Tes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical

5 State

Registrar

29a. Certifier (Check

only one 29b. Signature and title of ce

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AGUNCION

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

November 6, 2012

berty Mill Road, Germantown, MD

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cotton October Physician/ Medical Examiner 4a. Facility Name (if not institution, give street nestertowa Age (In yrs. last birthday) **Funeral** 214-52-0266 Director 1 XM 2 🗆 F 65 05/02/1947 Yrs. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director MD Kent Rock Hall 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6323 Obama Road 21661 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Seafood Department of Health and Mental Hygier Important: If item 27 is marked other I any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Allen McKinley Adele Virgina Wicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Sisco/Sister 6323 Obama RD Rock Hall, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holy Trinity AME 11/10/2012 Rock Hall, 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Bennie Smith Funeral Signature of Funeral/Service Licenses 855 High Chestertown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic AdenoCavelnoma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BPHEObstruction Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown To Be Completed 24a. Was an has performed Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral [Medical 29a. Certifier (Check only one) To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

2210

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2X No

MD

Black

14. Race - American Indian, Black, White, etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

4c. County of Death

Ken

USA

Specify.

2 🗌 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🏿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PeilStaddard MD 100 Brown St 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38676 State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 30 201^{Year} CATHERINE CROFT CLEVENGER 7:45 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 7015 BRIDGEPOINTE DRIVE CHESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 404-24-4694 **Director** 1 □ M 2 🗶 F Yrs. 89 KENTUCKY 10/17/1923 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD OUEEN ANNE'S CHESTER the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a c t be n Funeral filed within 72 hours after death with must b 7015 BRIDGEPOINTE DRIVE 21619 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. , or by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. If Yes, Give 3 X Widowed 4 Divorced Specify: WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other than 12 JUDGE OF ORPHANS' COURT JUDICIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I t. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ပ JAMES E. CROFT CARRIE MAE HUMPHRIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA NIEHUS / DAUGHTER 1422 PENNINGTON LANE SOUTH, ANNAPOLIS, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. X Burial 2 Cremation 3 Removal from State WOODTE TO WOOD 4 Donation 5 Other (Specify) 11/05/2012 EASTON, MD 21. Sign fur of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final obstructive Ph. i ian oulmonary disease or condition resulting in death) hronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to infinite cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or injury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical SBS the at ending IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔊 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 **X** No Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

completely filled in by 24 hours : Funeral I To the within 2

s after death.

the

Certificate:

Medical 29a.

1 X Natural 2 Accident

3 Suicide

4 Homicide

5 Pending

Investigation

determined

6 Could not be

only one)	3 Certifying Nurse Practitioner: To the best of my knowledge,	death occurred at the time, date and place, and due t	to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investi		
Certifier	1 Z Certifying Physician: To the best of my knowledge, death or		

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year) 21, 2012

28d, Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Pynt)

1630 MAIN STREET, MD 21619 CHESTER.

work? 1 ☐ Yes 2 ☐ No

MICKI A. KANTROWITZ, MD 82. Registrar's 31. Date filed (Month, Da

State Registrar iniury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. nt's Name (First, Middle, 2. Date of Death ooke Physician/ Year 0930M a 2012 NOV Medical 4a. Facility Name (if not institution, give street and number) 4b_City, Town, or Location of Death 4c. County of Death Examiner Sandallstown 50 Northwe 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Hours Min. 218-92-7574 8/21/1960 **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director 28a-f Baltimore Pikesville 1 ☐ Yes 2 No MD 10f. Zip Code 10e. Street and Numbe ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21208 USA 741 Howard Rd. permit. Page 1 and 2 should be filled within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Mental Mental Once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Charity volunteer non profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ James Wiley Cooke Venus June Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5300 Highcastle Court, Fort Collins, CO 80525 Jenine Stockdale, sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cooke Family Cemetery 11/8/2012 Bakersville, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 remmer 934 S. Hampstead. Main St. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death diseas artherosch Ph_sician/ erotic cardiovascu disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a social equerice of). Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 6 1 Tyes _2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. From the continues be signed by the attending physicis. P.O. Box 68760 Records, **Division of Vital**

with the Maryland

Maryland 21215-0036

Baltimore,

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu

State Registrar

Medical

29b. Signature and title of certific

3 [

Investigation 6 Could not be

determined

Accident

Suicide

4 Homicide

29a. Certifier

D0063918

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

NOV 2,2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dionne J. Smith, MD, 5401 Old Court Road, Randallstown, MD 21133

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 20 ใว้ 4:30AM JOHN FRANKLIN COVER SR. Medical 4a. Facility Name (if not institution, give street and number)
HERITAGE HARBOUR HEALTH AND
REHABILITATION CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number Hours Min 12/20/1928 Director 219-22-7564 1 🕅 M 2 🗆 F 83 MARYLAND in then "neturel", or itema 23a or 28e-f ahov the Madical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours efter deeth with the Meryland Director MD QUEEN ANNE'S STEVENSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 126 SOMERSET ROAD 21666 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "ne any injury or other traumetic event, the Mades once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) FABRIC SALESMAN 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN S. COVER MARY O'BRIEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 SHORE WALK ROAD RIVA, MARYLAND 21140 JEFFREY G. COVER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY: 11/05/2012 STEVENSVILLE, MD 21. Signature / Funeral Sarvice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician azchac ease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospitel or Attending Physician: The lew requires that the death certificate be executed within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ❤️☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cocenama 24a. Was an autopsy Yes P No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital |은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🜱 🖸 Certifyind Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one 29b. Signature and title of ce 29d, Date signed (Month, Day, Year) Name and address of de

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or							gible.	
		For State	State of	Marylan	•			d Mental Hy	giene		20070
		Registrar 1. Decedent's Name (First, Middle, L	act)		Cen	tificate of L	eath	O Data of Da	Reg. No.	117	385/9
Physicia	n/							2. Date of De	er 04,	2ŎĨ2	3. Time of Death 4:24 P.M
Medic Examin		James Russell C 4a. Facility Name (if not institution, g		oer)		4b. City, Town, or	Location of De			ty of Deat	
LAditiiii	CI	Calvert Memori					ce Fred			alver	
Funeral				7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours M				thplace (State or Foreign untry)
Director		218-42-2425	1 🛣 M 2 □ F	68	Yrs.	monario = ayo	1.00.00	03/23/			ryland
and show	or	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	ation		100/20/	1777	1101	10d. Inside City Limits
Maryla Ba-f s tified	rect	MD Calver	t	Du	nkirk						1 ☐ Yes 2 💢 No
the la or 2 be no	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Co	untry?
h with	nera	11220 Country R	oad			20754			USA		
r iten		11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Ford 1 Yes		S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - Ame	rican Indian, e, etc.
s after al", o Exam	d by	3 Widowed 4 Divorced	1 ☐ Yes If Yes, Give Year or Dat		1	☐ Yes 2 🛣 No	Specify:		Speci	^{fy:} Whi	to
hour natur dical	Completed	15. Decedent's (Specify only highest	s Education			ent's Usual Occup			16b. Kind of		
nin 72 he. .han " e Me	omp	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	Ìife. DO	ind of work done of NOT use retired)		vorking			
d with tygier ther t nt, th	Be C	8 17. Father's Name (First, Middle, Las			Union	<u>Carpente</u>			Const		ion
be file ental l- ked o c eve	To E	John Vinton Cha	,					Name (First, Middle, Marie Ph		ne)	
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship			19b. Mailing	Address (Street a		Rural Route Numbe		State. Zir.	Code)
d2shaaltha altha 27is ertrau		Steven J. Chane	v. Son					Anacort			· ·
of He of He fiter		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. P	lace of Dispos			Date	20c. Location		
Page ment tant: I		4 Donation 5 Other (Spe		raic	ropoli	tan Crem	atory 1	1/7/2012			
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service Lice	ensee		22.	Name and Addres	ss of Facility R	ausch Fu	neral H	ome,	
	_	23a. Part 1. Enter the disease, or co	mplications that or	MOO7				Lane, 0		MD 2	20736 Approximate
Dhysisian/		shock, or heart failure. List only Immediate Cause (Final			. Do not sints	4.	^	*	, ,		Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	a. Due to (c	OV G M Q or as a consequence	iençe of):	rkery	1213	sease		+	
Examiner		Conversion lies and states	H	41000	Yens	ion					
n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	r as a consequ	ience of):	,					
cate be executed physician and s the burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (c	r as a consequ	lence of:						
oe exe	= 1	resulting in death) Last	des.	as a consequ	101100 017.					- 1	
icate l	Physician/Medica		d								
eath certifica attending ph I for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			Ectopic pregnance			23d. D	Date of del	ivery
death	sicia	in the past 12 months? 1 Yes 2 No		ant at time of c		Other (specify)	У		N	/lonth	Day Year
requires that the de been signed by the should be detached	Phy	9 Unknown Part II. Other significant conditions			ulting in the un	derlying cause giv	ron in Part I	00- Dida		-4-3144	the cause of death?
es that signed	d by	Taren. Other signment conditions	recitalibating to de	attribut flot fest	aiting in the an	derrying badse giv	ciriii raici.				robably 4 Unknown
requii been shoulk	Completed							24a, Was			topsy findings available
The law	dmc							auto	psy ormed?	prior to death?	completion of cause of
an: Th tificate tor, pa	Be Co	25. Was case referred to medical	<u> </u>			26. Pla	ace of Death (C	heck aniv one)	2 No	1 Yes	2 No
Physician: This certifice	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	npatient 2 X	ER/Outpatient	1 400	er.	Home 5 Resi	dence 6 🗆 Ot	her (Spec	ify)
ting Ph n. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date o		28b. Time of injury	28c. Injury work	at		now injury occu		<u></u>
tendi leath. tor: A the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	t be			M 1 □	Yes 2 No				
l or At after d Direct I in by	Cert	4 Homicide determine		of Injury - At ho g, etc. <i>(Specify,</i>		et, factory, office		28f. Location (City or Tov		ber or Rur	ral Route Number,
ispital or hours afte neral Din y filled in	ical	29a. Certifier 1 X Certifying P	hysician: To the be	st of my knowle	edge, death o	ocurred at the time	e, date and plac	e, and due to the c	ause(s) and ma	nner as st	ated.
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2 Medical Exa	miner: On the basis urse Practitioner:	s of examination	and/or investig	gation, in my opinic	n, death occurre	ed at the time, date a	and place, and c	lue to the c	cause(s) and manner stated.
North Control		29b. Signature and title of certifier	,			29c. License			29d. Date sign	ed (Month	, Day, Year)
_		(MH) Dry	G MD				258		11/5	106/	12
MI WE		30. Name and address of person wh						. 1	WD 00==	,	
v IV		Catherine I. Br	opny, M.I	o., Duni	kirk Me	edical Ce	nter, I	ounkirk.	<u>2075 עש</u>	4	

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stephanie Yvonne Cutchember 20 Tab NOV. 07:52 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mary's St. St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 214 98 6607 35 1 🗌 M 2 🔀 F 7/22/1977 DC 10d. Inside City Limits 10c. City, Town or Location Lexington Park 1 XYes 2 No St. Mary's 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 20653 21363 Bristol Ave. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 🗙 No 1 X Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School 5+ Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Williams Vincent Robert Cutchember 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40802 Kennedy Ct. Mechanics ville, MD 20659 Vincent Cutchember/Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/10/12 Leonardtown, MD 4 Donation 5 Other (Specify) Charles Mem.Cem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home Signature of Funeral Service Licensee Dusca Tonu 38576 Brett Way Mechanicsville,MD 20659 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Immediate Cause (Final SPIRATOR DAXS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

MD

Funeral Director

by

Completed

Be

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Examiner

Funeral

Director

notified 28a-f

ō must be

23a

items

"natural", or iter edical Examiner

Medical

the Me

27 is marked other traumatic event, the

permit. Page 1 and 2 should be filed
Department of Health and Mental Hyg
Important: If item 27 is marked othe
any injury or other traumair.

the Maryland

Baltimore, Maryland 21215-0036

the been signed by the attending p should be detached for use as

STEFFERSI

P.O. Box 68760

Division of Vital Records,

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Examine Physician/Medical Be Completed by ၉ Certificate:

after death within 24 hours at To the Funeral D completely filled it the

State

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? g Unknown

25. Was case referred to medical

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown

NOVEWIBER 4, 2012

24a. Was an autopsy 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending Investigation Accident Suicide Could not be 4 Homicide determined

ARREST

ENCEPHALOPATITY

28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

28f. Location (Street and Number or Rural Route Number,

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of SATRICLA GORNY MP ath (Item 23a) (Type, Print) ST. MARY'S HOSPITAL LEONARDTOWN, MARYLAND

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0, 2012 Physician/ Wenber. 0815 Merle Joseph Carbaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 8. Date of Birth
Sept. 2,1952 If Under 9. Birthplace (State or Foreign **Funeral** 220-52-1864 Mary land **Director** 1 XM 2 □ F 60 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 ☐ Yes 2 XNo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 230 any nitury or other traumatic event, the Madical Conce. Funeral 21217 Mt. Aetna Rd. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo 1 Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC Technician HVAC Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Ellsworth Gloria Shantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Bragg Dr. East Berlin, PA 17316 Christopher J. Carbaugh-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 XCremation 3 Removal from State Smithsburg Crematory 11-14-2012 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home re of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No 1 Yes 2 9 Unknown Unknown Part II. <mark>Othe<u>r s</u>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 1100 Certificate: To 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State; Medical 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 medical Canous Rd. lar State

Registrar

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ිනේ Baltimore.	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur 1	neral Service Licen	to of		PH	National A	Address	r'fn'a	LDI	FUNEF	RAL	SERV	/ICE	,P.A	
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Vis	I or Attend after death Director: A	je	4 Homicide	determined	28e. Place of Ir	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory, of	ffice		2	28f. Location (S City or Tow			or Rural	Route Num	ber,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and corperedly filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2	Certifying Phy Medical Exam	iner: On the basis of	examination	and/or investi	gation, in my	opinion.	. death oc	curred at t	the time date a	and plac	e and due t	o the cau	se(s) and m	anner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g934 12-17-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Month Physician/ 21:45 Versie Virginia Clemons 4a. Facility Name (if not institution, give street and number) 11 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS Social Security Number 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 4/18/1923 Months Days Hours **Director** 1 - M 2 2 F TN 89 Yrs 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland at **Funeral Director** must be notified 1 Yes 2 No Oldtown Allegany MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a USA 18603 Coco Rd 21555 SE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed white other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once. မ Annie Wallace Howerton Floyd Howerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland, MD 21502 Mary Jane Roush/daughter 129 Gleason St. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Page 1 11/16/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Speoffy) Balt.National Cem. 22. Name and Address of FacilityScarpelli Funeral Home 21. Signature of Fur eral Service 108 Virginia Ave. Cumberland, MD21502 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a INTRACEREBRAL HR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit CERTIFICATION APPROVED BY MEDIC and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Year Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown been signated by should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? hours after death.

neral Director, After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Yes 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOV. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Flonn St 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 45 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death AltonoRE BANGTORA KEHAD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 420-26-7665 Days Hours Min. **Director** 1 M 2 M 5 -1917 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rectified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 es 2 No MD BALTIMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral FRANKFURD AUE. 5009 21206 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. BLACK Completed 3 ₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL AIDE 13 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHESS WILLIAM HANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, ASSANDER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEM 11-14-12 150 インカンスニ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 140,000 2734 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMENE, A disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should has beer 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 2 1 ☐ Yes 2 ☐ No of Vital To Be 25. Was case referred to medical 26. Place of Death Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural Division 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08403 State of Maryland / Department of Health and Mental Hygiene Robert William Driscoll, Jr. Certificate of Death Reg. No 3 Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2012 2010 hrs Driscoll, Jr. William Medical Examiner Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Pittsville 8327 Whitesville Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex oreign **Funeral** Hours Country) MD 9-27-1967 Director 2 F 1 X M 45 216-02-1408 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 X No Pittsville 28a-f show pemit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If liten 27 is marked other than "natural" amortant of the perfect Wicomico 10g. Citizen of What Country? Director 10e. Street and Number USA 21850 8327 Whiteville Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: Specify: White If Yes, Give Year 4 X Divorced 16b. Kind of Business/Industry <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Automotive Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fatner's Name (First, Middle, Last) Disharoon Christine Driscoll, Sr. William Be Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Father Maryland 21801 27400 Waller Road, Salisbury, Robert_William_Driscoll, Sr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11-9-2012 Delmar, Delaware rematory of Delmarva Donation 5 Other Specify 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licensee Salisbury, Maryland 21804 705 E. Main Street, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical a Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attendiog Physiciao: The law requires that the death certificate be executed and -Physician/Medical UNPENDED AMENDED attending physician or use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 signed by the atter 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of certificate has been ector, page 2 should autopsy death? performed ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient ER/Outpatient 3 DOA 2 After this ဥ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) NoV 5, 2012 28c. Injury at Work' 28b. Time of Injury 27. Manner of Death Subject shot self Certification: 2010 hrs 1 Yes 2 ✔ No 1 Natural n 24 hours after death.

The Function of Function: A pletely filled in by the function of the 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 8327 Whitesville Road, Pittsville, MD 3 V Suicide Could not be (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 6, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

DHMH 17 Rev 1/2001 OCME 2006 Ana Rubio M.D., Ph. D.

В. Драго

Assistant Medical Examiner

32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of L	- Calli	2. Date of Deatl		12	3. Time of Death
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jiha .	Examin		4a. Facility Name (if not institution, give street and				Location of Death	-	4c. County		
Samuel Samuel			Calvert Memorial Hosp 5. Social Security Number 6. Sex	oital 7. Age (In yrs. las	t hirthday)	Prince I	Frederick	8 Date of Birth	Calve		ice (State or Foreign
F	Funeral Director		431-44-3279 Usual Residence of Decedent	1	Yrs.	Months Days	Hours Min.	Sept 30) 1928	Arkan	isas
	and show	ρ	10a. State 10b. County		Town or Loc					100	d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Calvert	St.	Leona						1 🗌 Yes 2 🏝 No
	with the s 23a or ust be n	Funeral D	10e.Street and Number 5225 Knights Bridge (Court		10f. Zip Code 20685		ť	og. Citizen of V Inited S	tates tates	y? 3
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. d Forces? Yes 2 No Give or Dates.	If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blac	- Americar k, White, etc	c.
2-0	2 hour	plet	15. Decedent's Education (Specify only highest grade compl	eted)	(Give k	ent's Usual Occupa	ation Juring most of work	ring	16b. Kind of Bu	ısiness/Indu	stry
121	ithin 7 ene. r than	Completed	Elementary/Secondary (0-12) Colle	ge-(1-4 or 5+)		NOT use retired) chers ai	de		public	schoo	1
land 2	be filed w lental Hygi rked othe ilc event, I	100	17. Father's Name (First, Middle, Last) Elza Pierce Burleson	n			18. Mother's Nam	ne (First, Middle, M C1 Cunnir	aiden Surname ngham)	
Jary	should and M		19a. Informant's Name/Relationship (Type, Print)	i j		g Address (Street &					
e, 1	and 2 Health tem 2;		Jo Deann Bowen-daught 20a. Method of Disposition	20b. Pla	ice of Dispo	Knights sition (Name of	11/6	<i>to</i> ana 1 2	20c. Location -		
Baltimore, Maryland	t. Page tment c tant: If jury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Met	netery, cren ropoli	tan Fune	ral Serv	ice /	lexand	ria Vi	
Bal	permit Depar Impor any in		21. Signature of Euneral Service Licensee		44	Name and Addres 05 Broom	<u>es Is. Ro</u>	l. Port E	<u>Republio</u>	ne PA	20676
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of	that caused the death. on each line.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate nterval Between Onset and Death
-	h, i i n Medical		Immediate Cause (Final disease or condition resulting in death)	Spiration of the state of the s	317	PREUI	nonia			_	Shoot and Boarn
	Examiner			e to thi as a conseque	rice orj.						
	- ·	iner	cause, Enter Undertying	e to (or as a conseque	nce of):						
	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a conseque	nce of):						
0	ate be executed physician and the burial-transit	edical I	d.								
68760	ificate ng phy as the	Medi	IF FEMALE:								
Вох	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnand Other (specify)	ey		23d. Dat Mo	te of deliver	y Day Year
s, P.O.	law requires that the nas been signed by the e 2 should be detach	þ	Part II. Other significant conditions contributing Acute Respirator		_	nderlying cause giv	ven in Part I.				cause of death?
ord	w requisite peer 2 shou	Completed	Hyponatremia	,				24a. Was ar			sy findings available pletion of cause of
Rec	The ate l	Com	Hypertensive Cord	io vasua	lar c	u's lase		perform	ned?	death?	□ No
ita	ician; Sertific rector,	Be	25. Was case referred to medical examiner?			_ Oth	ace of Death <i>(Chec</i> er:				
∑f V	Attending Physician: or death. ector: After this certific by the funeral director.	e: To	27. Manner of Death 28a.		28b. Time of	28c. Injun	4 ∐ Nursing H v at	ome 5 Reside			
ou c	nding lath. r: After ne funer	icat	2 Accident Investigation	(Month, Day, Year)	injury	M 1 □	? Yes 2 🗆 No				
Division of Vital Records,	I or Atten after deat Director: d in by the	Certificate:		Place of Injury - At homouilding, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (St. City or Town		er or Rural F	Route Number,
	To the Hospital or Attending Physician: whith 24 hours after death as a fifter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 3 Certifying Physican: To the control of the cont	e basis of examination	and/or invest	tigation, in my opinio	on, death occurred a	at the time, date an	d place, and due	e to the caus	e(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	· .	,	29c. License	e number		9d. Date signed	(Month, Da	ay, Year)
			eyan.	· vw	a		50653		11-6-	- 201	2
de	W 5		30. Name and address of person who completed 5951 - Deale (cause of death (Item 2		Print) GYA	N' C. Deale	SURAN	207	51	
	Sta Registra		31. Date filed (Month, Day, Year) NOV - 7 20	32. Registra's Signatu	, B.	hares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	aryland		artment tificate				jiene Reg. No.	012	386	87
	DI	,	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	th	V	3. Time of	Death
	Physicia Medic		Robert	Lee			Dell			Novembe	r 12,	2012	3:30	РМ
	Examin	er	4a. Facility Name (if not institution,						ation of Death			inty of Death		
	Formul		Williamsport Re 5. Social Security Number		Trage	t birthday)		iamspo	Inder 24 Hrs.	8. Date of Birth		Shingto	olace (State or	Foreign
	Funeral Director		284-12-7298	4 1 1 1 1 1	94	Yrs.			urs Min.	May 28,	Year 918	OH'	io	roreign
	mo u		Usual Residence of Decedent											
	ryland -f sh	cto	10a. State 10b. County			Town or Loc						1	0d. Inside Cit	
	r 28a notifi	Director	MD Washi	ngton	Wil	liams _p	10f. Zip C	'ode			10a Citizan	of What Cou		ZAJ NO
	vith th	ral	44 E. Village	Lane			1 '	795				.S.A.	iu y :	
	eath v	Funeral	11. Marital Status	12. Was Decedent I		13. V	Vas Deceder	nt of Hispani	ic Origin? (Sp	ecify Yes or No-		Race - Americ	an Indian,	
9	fter d		1 Never Married 2 X Marri	Armed Forces? ied 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, specify		exican, Puerto	Hican, etc.)		Black, White,	etc.	
Ö	tural	Completed by	3 Widowed 4 Divorced	Year or Dates.							Spe	Wh	ite	
5	72 hc In "na Aedic	uple	15. Deceden (Specify only highes	st grade completed)		(Give I	lent's Usual (kind of work (O NOT use re	done during	most of work	ing	16b. Kind o	of Business In	dustry	
212	within jiene.		Elementary/Seconday (0-12)	College (1-4 or 5	5+)		ister				Reli	gion		
DQ .	filed valued val	Be	17. Father's Name (First, Middle, La	ast)	Ė			18.	Mother's Nam	ne (First, Middle, I	√laiden Surn	ame)		
<u>yla</u>	lld be Ment arke atic e	욘	Howard Frankli	n Dell				R	hea Lu	cele Hol	mes			
Nar	shou hand 7 is m raum		19a. Informant's Name/Relationshi				_			al Route Number,				
e,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The filed them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Marjorie E. Del	LI/Wife	20h Pla	44 E ace of Dispo				/illiams _]		on - City or To	795	
JO L	permit. Page 1 a Department of I Important: If ite any injury or ot		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		ce	metery, cren	natory or oth	er place)	i	4/2012		-		
Baltimore, Maryland 21215-0036	mit. P bartme sortar r injur		21. Signature of Funeral Service Li		Joeus		. Name and			lest Have				
ñ	an ja ja		1 S. Muk.	Suiza		1	601 Pe	nnsy1		Ave., Ha			-	2
П			23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that caused ally one cause on each lin-	d the death. e.	. Do not ente	r the mode o	of dying, suc	ch as cardiac	or respiratory arre	est,		Approximate Interval Bety	
- 0	hysician/	83 1	Immediate Cause (Final disease or condition	ASPIR		S R	VEUN	IONII	4				Sonset and B	eath S
ألمسب	Medical Examiner		resulting in death)	Due to (or as		ence of):								
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687	rtifica ling pl e as tl	/Me	IF FEMALE:	00= 16										
Box	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3 L	Ectopic pre				23d.	Date of deliv Month		ear
ň	y the a	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	at time of de	Julii O L	3 Other toper	y/						
0.	v requires that the de been signed by the should be detached	by Pi	Part II. Other significant condition	ns contributing to death t	out not resu	Iting in the u	nderlying ca	use given in	Part I.	23e. Did to	bacco use c	ontribute to t	ne cause of de	ath?
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ta .	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other:	f Death (Chec					
> =	ding Physician: h. After this certific funeral director,	는 일	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpati		R/Outpatier 28b. Time of		. Injury at	Nursing H	ome 5 Resid)	
동	ath. :: Afte fune	icate	1 Natural 5 Pending 2 Accident Investig		y, Year)	injury	М	work? 1 ☐ Yes	2 🗆 No		,,			
Division of Vital Records,	or Attendation of Attendation of Street, Stree	Certificate:	3 Suicide 6 Could r		ury - At hon	ne, farm, stre	eet, factory, o	office		28f. Location (Si		mber or Rura	Route Number	∍r,
á	rital or ral Di								J					()
:	the Nospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours affer death. The Anours affer death. The Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	Physician: To the best of xaminer: On the basis of e	examination	and/or invest	igation, in my	opinion, de	ath occurred a	at the time, date ar	nd place, and	due to the ca	use(s) and mar	iner stated.
:	To the Hospital or within 24 hours after To the Funeral Directornpleted filled in b	Σ	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	pest of my	knowledge, c		icense num				manner as si gned (Month,		
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			30. Name and address of person v						, 00		0,0-1.	1	, , ,	
J	アーカ		TED HOWE	154 N. A		MAS	ST.	WILL	IAMS	PORT,	WD	>		
	Stat Registra		31. Date filed (Month, 1865) Year	32. Registr	ar's Signatu	ire .	alle			•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ November 9, 2012 6:00 Thomas Emory Delauter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 11403 Stonecroft Court Apt. 219A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Hours (Month, Day, Year) 219-72-7809 1 M 2 □ F Director 56 Sept. 1, 1956 Hagerstown, MD 2 should be filed within 72 hours efter death with the Maryland thit end Mentel Hyglene. 27 is merked other then "naturel", or Items 23a or 28e-f show treumetic event, the Mexical Examinar must be mutified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 🗌 Yes 2 🔀 No <u>Maryl</u>and Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21742 11403 Stonecroft Court Apt. 219A 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and 2 should be Department of Health and Mente Importent: If Kem 27 is merked ery Injury or other treumetic once. ၉ Gloris Ilene Thomas Charles Raymond Delauter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20014 Rosebank Way Apt 216 Hagerstown, MD Gloris I. Delauter (Mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park Nov.13,2012 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. 21. Signature of Funeral Service Lice 425 S. Conococheague St. Williamsport, MD 21795 23a. Part T. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition VD Physician/ DEN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospitel or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Tho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 N emia 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: After this certifica etely filled in by the funeral director. 25. Was lase referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

JW-3

State Registrar

29a. Certifier

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AXE Registrar's Signature

1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

0056413

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1954 Jerry L. Dixon Sr. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Allegany Cumberland WMHS Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
July 26, 1948 Days Hours Min Maryland **Director** 215-44-9040 1 **X** M 2 □ F 64 Usual Residence of De 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Maryland Frostburg Allegany 10f. Zip Code 10g. Citizen of What Country? 19520 National Hwy N.W. Funeral filed within 72 hours after death with 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) the 0 Owner & Operator Contractor n and Mental Hygier is marked other t traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Monta Important If Item 27 is marked any injury or other traumations. 2 Naomi R. Hoover Walter Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Barbara Dixon Wife 19520 National Hwy N.W. Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State November 18, 2012 Frostburg Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Į in the past 12 months? Pregnant at time of death
Unknown Day Month Year Yes 2 No 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 4a. Was an autopsy page perform 1 Yes 2 No 25. Was case referred to med 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending M 1 \square Yes 2 🗌 No ☐ Accident Investigation by the hours after deat Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 9b. Signatu

Registrar

State

5

900 Seton Drive, Cumberland, MD 21502

d address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

James <u>Raver</u> 0V **1** 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20 ľ^e2 11:59 A M Bernard Ray Eichelberger Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emmitsburg Frederick St. Catherine's Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 13X M 2 🗆 F Months Hours March 28 86 Maryland Director 217-28-6188 1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 K No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 United States 12713 Layman Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 6 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Cline John Eichelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 N. Boundary St., Ranson, WV 25438 Sharon May / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Restnayen November 10 1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Frederick, Maryland 2012 Memorial Gardens 21. Signature Lineral Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nastas disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Exam Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Day Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has be this certificate has ral director, page 2 s autopsy 25. Was case referred to medical examiner? sompleted filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending work:
1 Yes 2 No Accident Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certifie

ORTIE

of death (Item 33a) (Type, Print)

empel

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend #2 per MD FCHD TM 11/07/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 3. Time of Death November I, Physician/ 04 Tal 0411 A M Fiorella C. Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1.817 Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Hours Min. Director 562-08-7772 1 🗆 M 2 🖷 F Yrs March 17,1941 England 71 November Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 United States 682 West Side Drive death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ♠ No If Yes, Give Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Fiorela Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Michael Once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Maria Fillippi Abelardo Ivancich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Brian Evans, husband 682 West Side Drive, Gaithersburg, MD 20878 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan
Crematorium, Inc. 1 Burial 2 Cremation 3 Removal from State 11/5/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) al Service L ²². Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Fug M01393 The the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final Cancel Physician/ ung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 12 No
9 Unknown Month Pregnant at time of death 5 Other (specify) this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ā</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 8 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 ☐ Yes 2 🗗 No မူ 1 Inpatient 2 FER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of confie 29d. Date signed (Month, Day, Year) 29c. License number November 1, 22 D62553 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melical center Drive, rodoville, may land 20800 C 9901 M me Neil, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Lee Eanes, Jr. 2012 November 05:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MedStar Montgomery Medical Center Olney Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months 214-60-2072 59 **Director** 1 X M 2 🗆 F Yrs. Nov. 18 1952 Maryland Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Gaithersburg MD Montgomery 1 🗌 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 United States 6220 Griffith Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Remodeling Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Mildred Hodges Frances James Lee Eanes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 6220 Griffith Road, Gaithersburg, Maryland Bettie Eanes / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/07/12 Alexandria, Virginia Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fuver Sep 22. Name and Address of Facility Barber Funeral Home P. O. Box 5038, 20882 Laytonsville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a nonsequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached f 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arter. 0150050 2 Meral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 K Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Funeral Director: A within 24 ho

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 17904 Georgia Avenue, Suite 304, Olney, Maryland Ata Motamedi, M.D.

State Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day East Amy 2012 5:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Med star Baltimore BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 271-44-6519 1 □ M 2 🛣 F 51 1/7/1961 OHIO show or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MARYLAND ANNE ARUNDEL LINTHICUM ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6876 BALTIMORE ANNAPOLIS BOULEVARD 21090 UNITED STATES "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. þ 1X Never Married 2 Married 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify: Completed 3 Divorced Year or Dates. 1989 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RUSSIAN LINGUIST MILITARY NSA 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be STANTON TICE EAST JOAN ELIZABETH PASCHAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY EAST/SON 6876 BALTIMORE ANNAPOLIS BOULEVARD LINTHICUM, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESTEPEARE CREMATION CENTER 4 Donation 5 Other (Specify) 11/8/2012 STEVENSVILLE, 22 Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE B14 BESTGATE ROAD, ANNAPOLIS, MD 21401 Signature of Funeral Service Licensee nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Metastatic Esophageal cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner to Thrive Fallure Sequentially list conditions if any leading to in recipie cause. Enter Underlying Physician/Medical Examine attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending injury work? 5 Pending within 24 hours after death. To the Funeral Director, A Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 001 10/29/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hanover St, Baltimore MD 21225 Nishanthika

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Navoratnarajah

32. Registrar's Signature

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	and show at	.o.	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation		1 12	<u>ar on c</u>		10 110	10d. Inside City Limits
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e Z	and 2 Health em 27 ther tu		Sandra Y. Eng 20a. Method of Disposition	le/wife	20h F		1 Barre	<u>lviļ</u>	le Ro	,			or Town, State
altimore,	Page 1 lent of nt: If it		1 Burial 2 Cremation		n State	emetery, cre	matory or other pla					-	nd,MD 21502
salti	permit. Page 1 a Department of H Important: If ite any injury or ott	13	21. rignature and Service L		Jour	2:	2. Name and Addre	ess of Facili	lity				
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P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		9 ☐ Unknown Part II. Other significant condition			ulting in the	underlying cause g	iven in Part	t I.	23e. Did t	obacco u	se contribute	to the cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Earl Farrell Richard Physician/ 1200 ovember 20/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO TONISSULA REGIONAL MEDIENL SALISOUR If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 215-12-6805 Director 1 🛛 M 2 🗆 F 88 08/05/1924 New Jersey Usual Residence of Deceden Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumetic avant, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Meryland Director 1 🗆 Yes 2 🏝 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 133 Greenmount Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or DatesAmy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Paga 1 end 2 should be filad within 72 hours efter in nent of Health and Mantel Hygiane. ant: If Item 27 is marked other then "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Gasoline 10 Salesman Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Shockley Roy Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Greenmount Ave., Salisbury, MD 21804 Elsie M. Farrell/Spouse Department of Healt Important: If Item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial Park 11/15/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ²² Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCNO Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) within 24 hours after death. To the Funerel Director: Aftar this certificata hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be dateched for usa es the burlal-transit Hospital or Attanding Physicien: The lew requires that the death certificete be axecuted that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2**X** No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063199 11/12/12 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a 910 EASTERN SHORE DR. SALISBURY MD. 21804 VOHRA

Registrar

DHMH 17 Rev 06-2011

YOGES 4 V 31. Date filed (Month, Pay,

Ta 2012

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nonth Nov 6 6:26 PM >hella 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Maniland Medical Ballimore If Under 1 Year If Under 24 Hrs.

Martha Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 3-70-925 **Director** 1 M 2 TF June 14,1958 aryland or 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗷 Yes 2 🗆 No 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral reenwood Baltimore, Maryland 21215-0036 $\mathcal{J}|\mathcal{J}|$ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. o, 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No If Yes, Give 1 Yes 2 No Specify. "natural" 3 Divorced Completed Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medicall <u>once.</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Stock Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fletcher James Duront 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Deborah Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗹 Burial 2 🗌 Cremation 3 🗍 Removal from State 10/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Funeral
Sio Washing Home, P. washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ METOSTATIO disease or condition resulting in death) cante Medical Due to (or as a consequence of) Examiner 2012 Sequentially list conditions, if any teating to an inactiate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to for as a nonsequence of: The law requires that the death certificate be executed as the burial-trar and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Day Year 4 Pregnant g Unknown Pregnant at time of death 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2. performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a
-To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1093081515 November V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene St. Battimore, MD Rushing 22 Date filed (Mont Registrar's Signatur

State

Registrar

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mel 0430 M 2012 a 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Nursina Dorchester prida 7. Age (n yrs. last birthday) 8. Date of Birth If Under 9. Birthplace (State or Foreign Months Min (Month, Day, 5 Usual Residence of Deceden 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ✓ Yes 2 ☐ No ambrida 10e. Street and Numbe 10f. Zip Cod 10g. Citizen of What Country? 5 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) brker Manufact 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keyna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 W Burial 2 Cremation 3 Removal from State Bethe Cambridg 2012 4 Donation 5 Other (Specify) Funeral Home, P. A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nington 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Dancreatic Due to (or as a consequence of) athlevo scieratic accident month Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 menths? 1 Yes 2 No Day Pregnant at time of death 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician/ Medical Examiner Examiner

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit

Completed by Physician/Medical

Be

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Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Funeral

Director

or items 23a or 28a-f shov

other traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryl Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f son any injury or other traumatic event, the Medical Example.

Medical Examiner

10a State

Director

Funeral

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Completed

Be

2

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE:

25. Was case referred to medical

6 Could not be

NOV 08

determined

examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death

Natural

4 Homicide

Accident

Suicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2

☐ Yes 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 5 Pending Investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at 1 Tes 2 No

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

61

1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Coun bridge atter cia 100 ohnson Bramble

31. Date filed (Month, Day, State Registrar

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 05 Sara Louise Fragale 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Heritage Harbour Health & Rehab. Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8 Date of Birth 5. Social Security Number Funeral 7. Age (In yrs. last birthday) (Month, Day, Year) Director 235-38-6878 1 □ M 2 🗓 F 01/23/1929 West Virginia 83 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 United States 3701 Bayport Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) end Mental Hygiene. is marked other tha Entertainment Entertainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Marrotta Tony Gallo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8321 Quill Point Drive, Bowie, Maryland 20720 Frankie F. Moran/Daughter f Health of Heal Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 11/13/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signator of Fundal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ cellac Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use es the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Exar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♥☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate h
completely filled in by the funeral director, page 2- N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Med/ca/ Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) Name and add who completed cause of death

Registrar
DHMH 17 Rev 06-2011

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	State o	f Mandar	d/Do	nartment	of He	alth and	Monta	Hygion	٠.

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Darryl Jeffrey Fis		1- For State	tate of Maryla		artment of		nd Ment	al Hy		20 l	2 38699
Physicia	an/	Registrar 1. Decedent's Name (First, Midd	lle,Last)					2	2. Date of Death Month	h	3. Time of Death
Medical Exami	ner	Darryl Jeffre							November	4, 2012	0204 hrs
		4a. Facility Name (if not institution Bowie Health Center	on, give street and nu	mber)	ľ	b. City, Town, o	or Location of	Death		4c. County of I	
Funeral		Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Ye	ear If Under	24Hrs.	8. Date of Birt		9. Birthplace (State or
Director		247-90-7052	1X M 2 F	60			ys Hours	Min.	12/19/1		oreign Country) SC
	ł	Usual Residence of Decedent	1 <u>a</u> w 2			<u> </u>			12/19/.	1931	30
v any	ſ	10a. State 10b. County		10c. City	, Town or Locat	on					10d. Inside City Limits
land f shov	ō		ce George'	s Bow	ie						1 X Yes 2 No
Mary r 28a-	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What	Country?
eath with the Maryland items 23a nr 28a-f show ust be notified at once.	딅	12411 Whitehal		edent Ever in U	e 112 W/o	207. s Decedent of I-		in? / Sno	sify Vos or No	USA	American Indian, Black,
ath w	Funeral	1 Never Married 2 N	larried Armed Fo	orces?		es, specify Cub				White, e	
fler de	핏	3 Widowed 4 X Dir	1 Yes vorced If Yes, Give Yea	2 X No	1	Yes 2K N	lo specify:			Specify:	White
ours a atura	d by	15. Decedent's Education (Spe	or Dates: ecify only highest grad	de completed)		's Usual Occup				16b. Kind of Busin	ness/Industry
6 n 72 h ical E	Set	Elementary/Secondary (0-12)		,	1	•	16. 00 1101 1	250 / СШ С	<u>.</u>		
within giene.	Completed	17. Father's Name (First, Middle	2		Sal	es	18 Mother's	Name (Firet Middle M	Automot laiden Surname)	ive
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Lee Fisher	, 2031)						rrett	iaidon odinamo,	
213 ould b i Meni ic eve	2	19a. Informant's Name/Relations					eet and Numb	per or Ru	ral Route Num	ber, City or Town,	
MD d 2 sho lith and n 27 is		Michael Garrett	Fisher /							le, OH 43	
re, slan f Hea If iten		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal fro		Place of Dispos crematory or oth		emetery,	١	Date	20c. Location - Ci	ity or Town, State
Page Page nent of nent		4 Donation 5 Other S	pecify:		tro Cre	matory		11/8	/2012	Baltimor	e, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signal re of Funeral Service	Licensee							eral Home	
Physician	1	23a. Part I. Enter the disease, or	complications that complications	aused the death		12 NW C					715 Approximate Interval
/Medical		failure. List only one cause	on each line.				5 ,			,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of							
		Sequentially list conditions,	b								
	ë	if any, leading to immediate cause. Enter Underlying Cause		consequence of	of):						
d d	Examiner	(Disease or injury that initiated events resulting in death) Last		consequence o	of):						
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60, e be er ysician burial		UNPENDED	AMENDED							22d Date of de	lives
6876(certificate nding physics as the b		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		outcome of preg irth		aldeath 3	Ectopic	pregnand	су	23d. Date of de Month	Day Year
Box 6 e death cer the attendi	Sici		known	ant at time of de	eath 5 Oth	ner (Specify)					
he do hed	E I	Part II. Other significant condi	a		esulting in the u	nderiving cause	e given in Par	t I.	23e. Did tot	pacco use contribu	te to the cause of death?
, P.O.	þ		•						1 Yes	2 No 3	Probably 4 🗸 Unknown
	Completed								24a. Was a		re autopsy findings available
tal Records cian: The law requi certificate has been	臣								autops perform 1 ✓ Yes 2	ned? dea	
		25. Was case referred to medica	al			26.Pla	ce of Death (Check on		- NO 1	Yes 2 No
Vital bysician:	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5 F	Residence 6	Other:
n of \ding Pb;		27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. Time of Ir	njury 28c. In	jury at Work?	2	8d. Describe h	ow injury occurred	
tendi death.	Certification:	1 ✓ Natural 5 Pen 2 Accident Inve	stigation				Yes 2				
Divisior pital or Attend ours after death reral Director:	ţį		ld not be	e of Injury - At h	ome, farm, stree	t, factory, office	building, etc	. 2	8f. Location (Sour Town, St.		or Rural Route Number, City
E 6 5		29a. Certifier 1 Codifium B	(0,00)/	t of my line ()	lea death	rad at the time	data and -1		up to the	(a) and mare -	estated
To the Hos within 24 h To the Fun completely	edical	(0)	hysician: To the bes iminer: On the basis o	of examination a							
To the within To the comple	Med	29b. Signature and title of certifi	and manner s er	tated.		29c. Licer	nse number			29d. Date signed	(Month, Day, Year)
		anet				0.0	M.E.			November 5,	2012
0.10	-	30. Name and address of persor	who completed caus	se of death (Item	1 23a)						
UH5 1		Ana Rubio M.D., Ph.		/ledical Exa		W. Baltimo	re Street,	Baltimo	ore, MD 212	223	
St Regist	ate	31. Date filed (Month, Day Year)	8 2012 32. R	gistrar's Signati	ure A. And	uks					

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician / Medical razier vovember Vorman 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Baltimore 8. Date of Birth (Month, Day, Year) Feb. 9, 1987 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 X M 2 □ F 25 218-13-6608 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a State 10b County 1X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code death with 21740 USA 1307 Lindsay Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force 2 should be filed within 72 hours after or and Mental Hygiene.
is marked other than "natural", or item 1 Yes 2 If Yes, Give Year or Dates 2 X No 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1x Yes 2 No Specify: hispanic Specify: black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) home improvements construction worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be · dTyr.

I and 2 should be
I Health and M Norman Allen Frazier Marlene Darnette Frazier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marlene Frazier - mother 11220 Pepper Bush Circle, Hagerstown, Md. 21740 Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hagerstown Crematory: 11/13/12 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or 23a. Part 1. Enter the disease, or co shock, or heart failure. List only one cause Immediate Cause (Final **Physician** Due to (or as a collequence of) 2 HRS ICAPEXAMINER disease or condition resulting in death) /Medical **Examiner** FEMILICATION AS KONED BY M Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No Yes be detached P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 Tes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has 2 🗌 No 2 X No 1 TYes 1 TYes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural vehicle accident and 1 ☐ Yes 2 🗙 No 11/11/12 s after death. 2 Accident filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, lace of injury - At home, farm, street, factory, office building, etc. (Specify) determined building, etc. (Specify) ROOWOY

City or Town, State)

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City or Town, State)

City or Town, State) 4 - Homicide 24 hours 29a. Certifier within 24 hor To the Funer completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

IW-0 State

Ghaleb

29b. Signature and title of certifie

orwareh 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

2012

November, 12

Registrar

29c. License number

RESOOO

	AME	ND	Please 29D, PER MD G934	Type or Pri 12/20/12.T	nt in Black I	ndelible Ink	c. Ensure A	All Copies	Are Leg	ible.	
		1	For State Registrar	State of M		artment of F rtificate of D			eg. No 20	12	38701
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of Deatl	n		3. Time of Death
-	Medic	al .	Gloria 4a. Facility Name (if not institution, give	Ann	Finch	4h City Town or	Location of Death		3, ^{Da} 2012		4:22 AM _M
- 10	Examir		WMHS-RMC	Street and Hallison)		Cumbe	erland		Alle	gany	
	Funeral Director		5. Social Security Number 506-44-3503 Usual Residence of Decedent	ех 7. Ag	73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1939	9. Birthplac Country)	ce (State or Foreign IA
	th the Maryland 3a or 28a-f show be notified at	rector	10a. State MD 10b. County Alleg	any	10c. City, Town or Lo	stburg				10d	. Inside City Limits 1 Yes 2 No
	with the Is 23a or 2	Funeral Director	10e. Street and Number 93 Teaberry Lar	ie		10f. Zip Code	21532	1	0g. Citizen of V	What Country USA	?
920	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	ह	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Bearing Armed Forces 1 Yes 2 If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cubar X 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American k, White, etc Whi	
15-0	72 hou in "natu Medical	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occupa kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of Bu	usiness/Indus	stry
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Maryland 21215-0036	id be filec Mental Hi arked otl atic even	To Be	17. Father's Name (First, Middle, Last) Clair Finch				Ann F				
, Mar	ge 1 and 2 should be filed within 72 hours aft tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, the Medical Exa		19a. Informant's Name/Belationship (i Sharon Irwin	Type, Print)		3 Teaberry					
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		Viemoriai Pa	rk	11/19/2012	20c. Location - Dalla		TX
Ball	permit Depart Impor any in	ļ	21. Signature of Funeral Service Local	M	2	2. Name ar Søærpe 108 V i	ekli₁Formeral H Irginia Avenu		ind, MD 21	1502	
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Ö	Medical		Immediate Vause (Final disease or condition resulting in death)		CARDIAL a consequence of):	INFA	RCT			-	nset and Deam
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P.O.	iaw requires that the ias been signed by the 2 should be detach	by Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.				cause of death?
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talF		Be	25. Was case referred to medical examiner?	Hospital:		0.1	ace of Death (Chec		- NO	- 100 2	
Ţ	shys this al di	유	1 Yes 2 No 27. Manner of Death	1 Inpati	ent 2 ER/Outpatie		4 ☐ Nursing H	ome 5 Reside			
o uo	ng Ine	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y, Year) injury	work		Zod. Describe no	w injury occurr	eu	
Division of Vital Records,	To the Hospital or Attending R within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certificate:	3 Suicide 6 Could not 4 Homicide determined		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town		er or Rural Ro	oute Number,
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	iner: On the basis of e	my knowledge, death xamination and/or inves se best of my knowledge	tigation, in my opinic , death occurred at t	on, death occurred a he time, date and p	t the time, date and ace, and due to the	d place, and due e cause(s) and n	e to the cause nanner as stat	e(s) and manner stated. ted.
	3 with 200		29b. Signature and title of certifier			29c. License			9d. Date signed		
	,		30. Name and address of person who		leath (Item 23a) (Type,	Print) owbrook	0. 0	1_ 1	1	1 - 0 1	
	Nol Sta	P.	(haves Mo		ar's Mgnature	owbrook	KD C	um Der	land, r	nd 3	21502
	Registr		MON TO SOIS	Cheer	D. Dark						

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			For State	State of Ma	ryland					and M	1ental Hy	giene	201	2	38702
1			Registrar 1. Decedent's Name (First, Middle, Last	1		Cert	ificate	OT D	eatn	_	2. Date of Dea	Reg. No	o.C. U 1		3. Time of Death
	Physicia		James W. Grant								Novemb		1 2 T	[2	17:04 M
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, T	own, or	Location o	of Death			c. County of D	eath	
N.		•	Atlantic General H	ospital			Berl	in				1	Worcest	er	
	Funeral Director		5. Social Security Number 6. Se 254-10-3103	7. Age ((In yrs. las 94	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 09/26/1	y, Year)		Birthpla Countr eor	
<u>. </u>	nd how at	<u>ا</u>	Usual Residence of Decedent 10a. State 10b. County	1	10c. City,	Town or Loca	ation							10	d. Inside City Limits
Ŏ	faryla Sa-f s tified	Director	PA Philadelph	ía	Ph	iladelpl	nia								1 X Yes 2 □ No
T	vith the N 23a or 23 st be no	eral Dii	10e. Street and Number 5411 Media Street				10f. Zip	Code 1913	31				itizen of What	Count	ry?
0.00	eath v	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	. 13. W	as Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No-		14. Race - A		
	21215-0036 within 72 hours after dogene. er than "natural", or if, the Medical Examine.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give W W Year or Dates.	° II	1	Yes, specif	,		i, Puerto	Rican, etc.)		Black, W Specify:	hite, el 31ac	
Ω	5-0 2 hour "natu	plet	15. Decedent's Ed (Specify only highest gra			16a. Decede	nd of work	done di		t of worki	ng	16b. I	Kind of Busine	ss/Ind	ustry
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0	/land be find the fin	임	Samuel A. Grant,	Jr.					Fred	die	Car	ter			
0	Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Edward A. Todd/g	. ,							Norrist				
5	Baltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐	Removal from State	ce	ace of Dispos	atory or oti	her place			Oate		Location - City		
··	altin mit. Per partme portan injury		4 Donation 5 Other (Specify 2). Signature of Funeral Service Licens		μνу						0/2012 l3 Jerse				sbury, MD
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< 71	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	lications that caused to each line.	he death	Do not enter	the mode	1	such as		or respiratory an	rest,			Approximate Interval Between Onset and Death
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	ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed ar death. setor, After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal	death 3 🗌	Ectopic p Other (spe		у				23d. Date of Month		Oay Year
=	P.O.	by Ph	Part II. Other significant conditions co	ntributing to death but	t not resu	ılting in the ur	derlying c	ause giv	en in Part	1.	23e. Did to	obacco	use contribut	to the	e cause of death?
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7-	Rec The la rate ha	Com	Demen	tin							perfo	ormed?			2 🗆 No
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0	f Vi Physi this c	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Lampatier 28a. Date of injury		ER/Outpatient 28b. Time of		Othe	4 🗀 N		me 5 Residence 128d. Describe 1			pecify)	
2007	in of oding Ph th. After the funeral	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	M	work'	? Yes 2		Zou. Describe r	iow inju	ary occurred		
	ع ۾ ∯ ۾ ⊆	Certificate	3 Suicide 6 Could not by 4 Homicide determined				et, factory,	office			28f. Location (S City or Tov			Rural I	Route Number,
DS W	Hospit 24 hour Funera	Medical	(Check 2 Medical Exami	ician: To the best of m ner: On the basis of exa e Practitioner: To the	amination	and/or investi	gation, in n	ny opinio	n, death o	ccurred at	t the time, date a	and plac	ce, and due to t	he cau	se(s) and manner stated.
James	To the vithin 2 To the comple	<	29b. Signature and title of certifier And Tion	us Seemo	l.	anp	29c.	License	number				ate signed (1/1		lay, Year)
	5 NA		30. Name and address of person who of	ompleted cause of decree nyord		23a) (Type, Pi	int) Tea/th	way	A	Ne	Berlon	, M	10 21	8/1	
aramit	Sta Registr		31. Date filed (NOTE) Pay1Y3 201	2. Registrar	's Signa		Ked								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year :30 P 0 M ovember 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Elizabeth Wrsing None en MOY 5. Social Security Number If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 D A **Funeral** 1 M 2 XX Days Nov. 5.1919 Hours Min 197-22-6802 92 PA Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MDNone Baltimore 1XX Yes 2 ☐ No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3320 Benson Avenue 21227 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. Specify: White 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Adam Krystyniak Victoria Glowacki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Victoria Barr/Daughter 6197 Greenblade Garth,Columbia,MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 4 Donation & Other (Specify) Entombmen cemetery, crematory or other place) Greenridge Mem.Park Nov.9,2012 Connellsville, PA 21. Signature of runeral reryica Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Mona disease or condition round 6 Medical resulting in death) as a consequence of) Examiner ure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury emi that initiated events resulting in death) Last and Due to (or as a consequence of): -burialattending physician for use as the buria Physician/Medical emen Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has bage 2 s autopsy performe After this certificate 1 ☐ Yes 2 ☐ No 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ျ 1 🗌 Yes 2 X No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 2 | No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20/2 ovembe

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rec

(Month, Day, Year)

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strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Greene ames Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death apitol 8. Date of Birth (Month, Day, Year, If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. **Director** 1 **X** M 2 □ F North Carolina 23a or 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 161al Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Se College (1-4 or 5+) and Mental Hygie is marked other Be 17. Father's (Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Fout: Number, City or Town, State permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other) 20c. ocation - City or Tonn, ate Date 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility FREETY APA FUNERAU SENVICES 4594 Beec mo 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshiratory arrest, shick, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at ald be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Daughter ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 K Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 65:4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 Ur State 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BORAH > ROVES Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 110 Trent Hall Court Friendship Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 218-68-3515 Director 1 □ M 2 🗓 F Yrs 09/10/1954 Washington, D.C Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MDAnne Arundel Friendship 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Trent Hall Court 20758 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed Year or Dates Wh<u>ite</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Giant Food Stores <u>Delicatessen Clerk</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ t. Page 1 and 2 should be thent of Health and Men rant. If item 27 is marke Baldwin Mary Ellen Mazzulo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest F. Groves, Son P.O. Box 6, Friendship, MD 20758 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 s
Depertment of H
Important: If ite
any Injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 11/13/12 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1190NJ7775 Physician/ ANCREAS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2/ No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) venta 13 2012 who completed cause of death (Item 23a) (Type, Print) LRU

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2

		-	For State Registrar	Otate of Maryle		tificate of l			Reg. No.	30100
	Physicia	n/	1. Decedent's Name (First, Middle, La	,		DMAN	-	2. Date of Dea Month NOV .	_	3. Time of Death
	Medic	al	JOHN 4a. Facility Name (if not institution, giv	EDWARD	GU	RMAN	r Location of Death		7 2012 4c. County of Deat	7:26 A M
	Examin	er	5 BRUSH ISLAND			BERLI			WORCES	
	Funeral			Sex 7. Age (In yrs	: last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day AUG. 11		thplace (State or Foreign
	Director		087-26-1944 Usual Residence of Decedent		76 Yrs.			AUG. 11	, 1936 I	YORK_
	/land f shov ed at	itor	10a. State 10b. County	10c. (City, Town or Loc	cation				10d. Inside City Limits
	e Mar r 28a- notifie	Direc	MARYLAND WORCE	STER	BERLIN	10f. Zip Code				1 Yes 2 X No
	with th	Funeral Director	5 BRUSH ISLAND	COURT		21811		ļ	10g. Citizen of What Co USA	ountry?
	items	Fun	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
36	after on II", or xamir	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		☐ Yes 2 ☐ XNo		7,110471, 0107,	Black, White Specify:	e, etc. VHITE
9	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "hadical Examiner must be notified at matic event, the Medical Examiner	Completed	15. Decedent's		16a. Deced	lent's Usual Occup	pation		16b. Kind of Business	
2	hin 72 ne. than "leece Mec	ошо	(Specify only highest g	College (1-4 or 5+)	life. DO	O NOT use retired)		ang	DELTOTO	7
2	filed with al Hygier d other i event, th	o l	17. Father's Name (First, Middle, Last)	8		ATHOLIC		ne Æirst Middle	RELIGION Maiden Surname)	
laŭ.	l be fill fental rked c	ပု	JOHN E,	GORMAN			MONI			S
Maryland 21215-0036	sho is au		19a. Informant's Name/Relationship (1				; City or Town, State, Zip	
	1 and 2: if Health item 27 other tr		REV. JOSEPH P. K		5 BR		ND COURT	-	, MARYLAND	
Baltimore,	age 1 ent of I nt: If its y or or		1 X Burial 2 ☐ Cremation 3 [4 ☐ ponation 5 ☐ Other (Spec	Removal from State	cemetery, cren	natory or other place NZ CEMET		Date 16/12	20c. Location - City or MILWAUKEE,	· .
alt:	permit. Page 1 Department of Important: If i any injury or once.		21. Sign ture Fineral Service Licer	A //		. Name and Addre		10/12	TILDWAUKDD,	WIDOONDIN
m			Trules W	Hux	7 HA	STINGS F	UNERAL H	OME, SEL	BYVILLE, DI	E. 19975
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line.				or respiratory arr	est,	Approximate Interval Between Onset and Death
	Medical	8 9	Immediate Cause (Final disease or condition resulting in death)	a. Motastati Due to (or as a conse		reatic o	rancer			Oriset and Death
	Examiner			Due to for as a conse	equence on.					
	7 E	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	ecuter and I-trans	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			■ d.						
8760	tificate ng phy as the	Physician/Medical	IF FEMALE:							
% 68	ith cer ittendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
P.O. Box	he dea y the a ched f	nysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of Unknown	ordeath 5 L	Other (specify) _				
P.0	that the	by Pl	Part II. Other significant conditions	contributing to death but not i	resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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000	law re has be je 2 sh	Completed						24a. Was a autop		topsy findings available completion of cause of
<u> </u>	in: The ificate or, pag		25. Was case referred to medical	I		26 P	lace of Death (Chec	1 🗆 Yes		3 2 □ No
Zita ≷ita	Physician: T r this certifice ral director, p	To Be	examiner? 1 Yes 2 M No	Hospital:	☐ ER/Outpatien	Oth	er.		ence 6 Other (Spec	ify)
Division of Vital Records,	ing Ph .fter th .neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. injur work	<u> </u>	28d. Describe h	ow injury occurred	
Sion	ttendi death stor: A the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	be 28e Place of Injury - At	home farm stre		Yes 2 ∐ No	28f Location (S	treet and Number or Ru	ral Poute Number
ĬŽ.	al or A s after l Direc d in by		4 ☐ Homicide determined	building, etc. (Spec		ot, lactory, office		City or Tow		rar rioute Number,
_	lospita 1 hours unera ed fille	Medical		ysician: To the best of my kno niner: On the basis of examina						
	the H thin 24 the F	Me		rse Practioner: To the best of			e time, date and pla	ce, and due to the	cause(s) and manner as	stated.
	X X 20			la mo			0053		29d. Date signed (Month November 8,	
	10		30. Name and address of person who	completed cause of death (It-		rint)				
	0			Carroll Street	c, Salis	bury, M	aryland	21801		
	Stat		31. Date filed (Month, Day, Year)	32. Fegistrar's Sig	nature	arkal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ecedent's Narne (First, Middle, Last) 2. Date of Death Time of Death Physician/ 1 Month Juember Medical Name (if not institution, give street and numb Examiner City, Town, or Location of Death 4c. County of Death 10 unns Hmure 10 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age In vrs. last hirthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 218-40-5562 0672571947 Director 65 1 🛛 M 2 🗆 F MD or 28a-f shov 10a, State 10b. County or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Queen Anne's Chestertown 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 330 Pine Tree Road 21620 USA permit. Page 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the M. Stell Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Houston Grinnell Sr. Azene Moore D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Grinnell/Wife 330 Pine Tree Road Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place Boardley Chapel AME Church 1 XBurial 2 Cremation 3 Removal from State 11/12/2012 Chestertown, MD 4 Donation 5 Other (Specify) 21. Signature Service I 22. Name and Address of Facility Bennie Smith Funeral Home 855 High ST Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any Lading Lammedet cause. Enter Underlying Cause (Disease or injury Examine Dire to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown After this certificate has been signed by the strungeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No Yes 2 No 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes in 24 hours after death.

he Funeral Director: After this completely filled in by the funeral direction. 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending 1 Yes Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2012 --000 PHO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M5 31. Date filed (Month, Day, State 32. Registrar Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:05 P M ROBERT FOSTER GRAHAM NOVEMBER 4. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs. 8. Date of Rirth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F 1171371934 NEW JERSEY Director 153-26-7665 77 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No CHESTERTOWN MD OUEEN ANNE'S 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral with UNITED STATES 21620 205 PRINCESS ANNE DRIVE 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: 3 Divorced 4 Divorced Completed Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) REAL ESTATE 12 SALES Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic **ELIZABETH HUTCHINSON** ARCHIBALD GRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 PRINCESS ANNE DRIVE CHESTERTOWN, MARYLAND 21620 NICOLE GRAHAM / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 11/06/2012 STEVENSVILLE, MARYLAND 21. Sign / re of Funeral Service Centee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MAYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): years disease or condition resulting in death) pulmonery Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Sypoventilatory Syndrome @ Morbid Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Hospital or Attending Physician: The 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 Yes 2 No n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 2 To the F 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

14/66hum, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

415 Washington Ave, Chestertown, MD 21620

D21313

11/5/12

			Please		Print in of Marylan								_	ible.	
_	1	For State Registrar			- Titlat ylati		tificate					Reg. N	00	12	38709
Physician Medica		1. Decedent's Name ((First, Middle, Las Lee Gru								2. Date of D		Day 08 3	Year	3. Time of Death 9:55 A M
Examine		4a. Facility Name <i>(if no</i>			nber)			Town, or	Location	of Death		- 1	lc. County Wash :	of Death ingto	n
Funeral		5. Social Security Nun	mber 6. S	ex	7. Age (In yrs. I	ast birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of B	irth			ace (State or Foreign
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s 23a oust be	Funeral	113 South	Artizan	Street			217	795					USA		
r death v	by Fur	11. Marital Status 1 ☐ Never Married	d 2 X Married	12. Was Dece Armed Fo 1 X Yes	edent Ever in U.s	S. 13. V	Vas Deced Yes, spec	lent of His cify Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-		e - America k, White, e	
urs afte		3 Widowed 4		If Yes, Giv Year or Da	e Vietn	am 1	☐ Yes	2 🔀 No	Specify.				Specify:	Whit	:e
72 hound no "math	Completed	(Speci	15. Decedent's E ify only highest gr	ade completed)		16a. Deced (Give F	lent's Usua kind of wor D NOT use	rk done de	ation <i>u</i> ni <i>ng m</i> os	t of worki	ing	16b.	Kind of Bu	usiness/Ind	lustry
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should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (Fir Raymond He		her							e (First, Middle Irene	,		e)	
nould burd Me s mark		19a. Informant's Nam	-			19b. Mailin	g Address	(Street a			al Route Numb			tate, Zip C	ode)
nd 2 sl lealth a m 27 is		Christy J		(Wife	· -				izan	Stre	et Wil	1			ryland 2179
age 1 a ent of H it: If ite y or ot			sition Cremation 3 5 COther (Special		State	Place of Dispo cemetery, crem	natory or o	ther place			Date 12 2∩1			City or To	wn, State t, Marylan o
permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.			ral Service Licens	<u> </u>	GLE	eenlawn	. Name an	d Addres	s of Facili	ty Osb	orne F	uner	al H	ome P	.A.
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the des	hysi	1 Yes 2 Unknown		9 🗌 Unkr	nown										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medic	Part II. Other signific	ant conditions o	ontributing to d	eath but not res	sulting in the u	nderlying (cause give	en in Part	I. 			1 -		e cause of death? ably 4 🗆 Unknown
w requ	plete										24a. Wa	s an opsy			sy findings available npletion of cause of
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rsician s certifi directo	To Be	25. Was case referred examiner? 1 \(\sum \) Yes 2		Hospital:	Inpatient 2	ER/Outpatier	t 3 🗆 D0	Otho	r'		k o <i>nly</i> one)	idence	6 Othe	er (Specify)	
ng Phy	ate: T	27. Manner of Death	5 Pending	28a. Date		28b. Time of injury		8c. Injury work	at ?		28d. Describe				· · · · · · · · · · · · · · · · · · ·
Attendi	Lific	2 \(\subseteq \) Accident	Investigation 6 Could not be determined		of Injury - At ho	ome, farm, stre	M eet, factory		Yes 2 L		28f. Location	(Street a	an <i>d Nu</i> mbe	er or Rural	Route Number,
ital or virs after	al Ce	4 🗆 Hornicide	determined	buildi	ng, etc. (Specif)	y)					City or To	own, Sta	te)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certificate:	(Check 2	Certifying Phy Medical Exam Certifying Nur	iner: On the bas	sis of examinatio	n and/or invest	ination in	my opinio	n death o	ccurred at	the time date	and place	ce, and due	e to the cau	se(s) and manner stated
To the vithir comp	-	29b. Signature and tit			1.	, , , ,	29c	. License	number	• 7 /	-			(Month, E	
		30. Name and addres	s of person who	completed caus	M J	23a) (Type F	Print)	03	07	//		11/	19/.	12	
W-8+1		229	11 Jes	CFUISO	n BI	VU .	5m 1	th)	sbu	7	ms				
State Registra		31. Date filed (Month,		112 32.	egistrar's Signa	my knowledge,	and the	•							
				Jan all		-7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, 25, 27, 28a-1, per me, 8936 2-2-13 sm State of Maryland / Department of Health and Mental Hygiene For State bring / MoCo Registra AMEND#23a(a,b,c)perMD, 11/5/12 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oct.22, Physician/ 2012 1426 Jose Ismael Garcia Gutierrez м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8/1/01/12/29/17998 0 9. Birthplace (State or Foreign El^{Co}Sa/Ivador 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 32 Director 051-90-5509 1 **№** M 2 🗆 F Usual Residence of Decedent or 28e-f shov or than "netural", or items 23e or 28e-f sho 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Prince George's Riverdale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 El Salvador 5425 56th Avenue Apt.5 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc \$ 1X Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No E.J. Salvadoran Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) none disabled Be permit. Page 1 and 2 should be filed Department of Heelth and Mental Hy Important: If item 27 is marked oth any injury or other treumetic event once. 18. Mother's Name (First, Middle, Maiden Surname) Blanca Garcia 17. Father's Name (First, Middle, Last) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5425 56th Avenue Apt.5 Riverdale, Md. 20737 Maria Zacarias/Companion 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gate of Heaven 1 X Burial 2 Cremation 3 Removal from State 10/29/2012 Silver Spring, Md 4 Donation 5 Other (Specify 21. Signature of Funeral Service Live PATETP ADES RINALDI FUNERAL SERVICE, P.A. Uh 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Complications of Head Injurie PNA

a. Approximate Interval Between Onset and Death Priysician. disease or condition resulting in death) Medical Due to (or as a consequence of):

Dessiminated Intravascular Coagulopathy
GI bleed Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) After this certificate has been signed by the ettending physician and funeral director, pege 2 should be detached for use as the buriel-fansit Hospital or Attending Physician: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 ☐ Yes 2 ☐ No Yes 2 X N 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 X Yes 2 **V**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours fler death.

To the Funeral Director. After this completely filled in by the funeral c 27. Manner of Death 28a. Date of injury (Month, Day, Year)

fd 8-19-2011 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 🛣 No 2 Accident
3 Suicide
4 Homicide unk Investigation 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Field 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5400 Block of Riverdale Rd. Riverdale Park, MD determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct. 22, 2012 D0073240 ress of person who completed cause of death (Item 23a) (Type, Print)
r MD 1500 Forest Glen Road Silver Spring, Md A.Kumar MD 31. Date filed (Month, Day, Year) State alle NOV 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State		State o	f Marylan		irtment d tificate d			and M	ental Hy	/gien Reg. N	20	12	38711
			Registrar 1. Decedent's Name	(First, Middle, Las	t)			imodio	0, 0,			2. Date of D		Doy.	Voor	3. Time of Death
	Physicia Medic	al .		. Grogh								Month	- 1	8 de		2340 M
	Examin	er	4a. Facility Name (if ra Western Medica	ot institution, give Maryla:	street and num nd Reg	ional		4b. City, Tov	~	nber		٦	4	4c. County	of Death equiv	
	Funeral		Social Security Nur	mber 6. Se	×	7. Age (In yrs. la	ast birthday)	If Under 1		If Under 2		8. Date of Bi	rth av Year			lace (State or Foreign
	Director		233-84-9 Usual Residence of		№ M 2 🗆 F	64	Yrs.	Worlding	,,,,	Tiodis		June		948		yland
	land show dat	tor	10a. State	10b. County			y, Town or Loc								1	0d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD 10e. Street and Num	Allega	ny	Cu	mberl	and	odo.				10- /	Citizen of V	Mhat Coun	1 Yes 2 □ No
	vith the	eral [235 Paca		t 405			215					l lug. (USA	What Cour	u y :
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	H	11. Marital Status		12. Was Dece	dent Ever in U.S	S. 13. V	Vas Decedent Yes, specify	t of His Cuban	panic Orig	jin? (Spec	cify Yes or No Rican, etc.)	-	14. Race	e - Americ	
36	after or samir	d by	1 X Never Marrie 3 ☐ Widowed 4		1 ☐ Yes If Yes, Giv Year or Da	2 No e	1	☐ Yes 2 🎗	≾ No	Specify:					Whi	
2-0	hours 'natur dical E	Completed by		15. Decedent's Ed	ducation		16a. Deced	lent's Usual O	ocupat	tion urina most	of workir	na —	16b.	. Kind of Bu		
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	be filed wi ental Hygie rked other ic event, ti	Be	1.7. Father's Name (F.	irst, Middle, Last)		-	ј ца	DOI GI				(First, Middle	, Maide	en Surname	=)	
ylar	ild be f Menta narked natic e	은	William						-			(Kes	_		_	
Maryland	12 should Ith and Me 27 is mar l r traumati		19a. Informant's Nar Ruth Northo					ng Address (Si aca St A							tate, Zip C	Code)
	f Hea item othe		20a. Method of Dispo		- I	20b. F	Nace of Diopo	aitian (Nama	of.		-			Location -	City or To	wn, State
Baltimore,	Page tment tant; It jury or		4 Donation	Cremation 3 ☐ 5 ☐ Other (Specified)	y)	Sca	emetery, cren		_					esapt	cown	MD
Ball	permit. Page 'Department o Important; If any injury or once.		21. Signature of Ean	eral ervice Licen)		\\ \frac{22}{5}\\ 1\\ 1	Name and A Carpe 08 Vi	idress III rgi	Full Full nia	hera Ave	l Hon	e I	A. land	MD	21502
Ö			23a. Part 1. Enter the shock, or heart	e disease, or com failure. List only o	olications that one cause on ea	caused the deat	h. Do not ente	er the mode o	of dying,	, such as	cardiac o					Approximate Interval Between
ndergy.	Physician Medical	6	Immediate Cause (F disease or condition resulting in death)		a	or as a consequ	C571	VE	1	15H	40	1-19	44,0	enc	5 ,	Onset and Death
	Examiner				. Jue to		EM.	100	1	nn	101	ny d	P	474	y .	YEARS
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6876	iath certificate be executed attending physician and for use as the burial-transit	/Mec	IF FEMALE:		23c If yes out	come of pregna	ancy							00.1.0		***
Box (ath ce attend I for us	Physician/Me	23b. Was decedent in the past 12 m 1 Yes 2	nonths?	1 Live 4 Preg	Birth 2 Feta	al death 3	Ectopic pre Other (spec		/					te of delive onth	ery Day Year
O. B	the de by the tachec	hysi	9 Unknown		9 Unki					. 5 .						
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ords	requir been s	Completed by	NIAR			TUS,						24a. Wa	s an	24b.	Were auto	psy findings available
3ec	The law tre has bage 2	omo	1/45/1		DISER							aut per 1 \sum Ye:	opsy formed s 2 🗷	?	prior to co death? 1 🔲 Yes	mpletion of cause of 2 No
tal	sician: The certificate irector, pag	Be	5. Was case referre examiner?		Hospital:		,		26. Pla	ce of Dear						
λ	Physi r this c eral dir	6: To	1 ☐ Yes 2 ☐ 27. Manner of Death		1 <u>4</u> 28a. Date	Inpatient 2 of injury	28b. Time of		. Injury	4 <u>□</u> Nu at		me 5 Re 28d. Describe				<u>')</u>
ono	ending sath. or: Afte he fun	ficat	1 Natural 2 Accident	5 Pending Investigation	1	th, Day, Year)	injury	М	work?	Yes 2 🗆	No					
Division of Vital Records,	f or Attending Phys after death. Director: After this d in by the funeral d	Certificate:	3 Suicide 4 Homicide	6 ☐ Could not be determined	28e. Place	e of Injury - At ho ing, etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, o	office			28f. Location City or To			er or Rura	Route Number,
Ω	pspital hours neral l	Medical	29a. Certifier 1	Certifying Phy	sician: To the b	est of my know	ledge, death	occurred at th	ne time,	, date and	place, ar	nd due to the	cause(s	s) and man	ner as stat	ed.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Mec	only one) 3	Certifying Nur	se Practitioner	r: To the best of	my knowledge	, death occurr	red at th	ne time, da	te and pla	ace, and due to	the ca	use(s) and r	manner as	
	6		29b. Signature and t	THE OF CEPTITIES	In.	-171	7	29c. L	Icense F	number	19		29d.	Date signe	d (ivioniti),	10/2
	43			ess of person who	completed caus	se of death (Iten	n 23a) (Type, F	Print)	ash	Caple	<i>Ed</i>	Cani	bole	and 1	n1)	21502
	Sta	te	31. Date filed (Month	n, Day, Year)	32. F	gistrar's Signa	-		- 60			Const :				
N	Registr			VOV 132	J72 /	as seemed	1. A	artel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day HALL ONALD 0800 M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) LANE HUNTINGT OWN WINDSOR ALVERI 3560 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Min. 1 XM 2 □ F 45 Washington DC 216-04-0553 Sept.29,1967 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 27 No Huntingtown Calvert Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20639 3560 Windsor Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2√1√No If Yes, GiveXX Year or Dates: 1 Never Married 2 TM Married 1 □Yes 2 □ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Estimator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MacGillvary Jean Donald F. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3560 Windsor Lane, Huntingtown, MD 20639 Teresa Hall - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 11. Clinton, Maryland Lee Crematory 2012 Lee Funeral Home Calvert, P.A. 21. Signature of Ineral Service Licensee 22. Name and Address of Facility 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SSUE SARCOMA Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🔀 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner Examine

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, Ilm. Once.

Physician

/Medical

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Masterl Exer direct must be redified at

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

and the attending physician asn ō has page 2 certificate

Physician/Medical

Completed

Be

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Certification:

Medical

1 Yes 2 ₩o

5 Pending investigation

6 ☐ Could not be

9

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

Box 68760.

P.0.

Division of Vital Records,

requires that the death certificate be executed this After t Hospital or Attending death. n 24 hours after death.

le Funeral Director: A
pletely filled in by the fi

the

within 7 2

29c. License number 29b. Signature and title of certifier 99. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 Certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2012

Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, 238 Prince Fued Merrimac 32. Registrar's Signature Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 2012 Physician/ Berneda Hester Handy Hall November 6:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8 Date of Birth Days Hours Min. (Month, Day, Year) Director 219-05-3315 1 🗆 M 2 💢 F 94 1-27-1918 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at another. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21 No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7406 East Adkins Avenue 21874 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 <u>Homemaker</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Handv Hester Barklev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) East Adkins Ave, Willards, MD 21874 Lucille Hall/Daughter 7406 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Cremation, 11-13-2012 Dover, DE 21. Signature of Furneral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home wasell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The lew requires that the death certificete be executed Cause (Discase or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day erai Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 🗹 No Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 1 Tyes 2 🗹 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: . Manger of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No **J** Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) mhe Nam November 5/5 2012 DO 51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 951. MT ROAD, JAUSBURY, 79 21604 DR. USHA NATESAN HERMON 31. Date filed (Month, Day, Year)

State

Registrar

32. Registrar's Signatur

NOV 0 & 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EVERETT J, HOAGLAND OCTOBER 30, 2012 8:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHESTERTOWN KENT CHESTER RIVER MANOR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1**X** M 2 □ F Months Days Hours 09/05/1919 CALIFORNIA 93^{Yrs} **Director** 348-01-5070 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 X No VENICE FLSARASOTA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34293 1927 INNISBROOK COURT UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates. 1941–46 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **ENGINEERING** 12 **ENGINEER** other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SUSAN PATTERSON OSCAR AUGUSTUS HOAGLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9522 FAIRLEE ROAD CHESTERTOWN, MARYLAND 21620 ROY HOAGLAND / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL UNKNOWN ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, Kuk SPEER ROAD CHESTERTOWN, MARYLAND 21620 Part 1. Enter the disease shock, or heart failure. L ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between tastati Immediate Cause (Final an ces Onset and Death Ph_sician/ 0)000 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence or) if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes this certificate has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?*
1 Yes 2 No Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After topleted filled in by the funeral Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Dav. Year

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MD

ted cause of death (Item 23a) (Type, Prin

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 11/08/2012, T.M., Kent Co Certificate of Death Amended#81 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ OCTOBER 2012 2:30 A JANET MACLAREN JOHNSON HEWES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT 4849 CIFF CITY ROAD If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In vrs. last birthday) 1924 **Funeral** Days 1 □ M 2**X** F Months Hours **88**Yrs. PENNSYLVANIA Director 160-24-4369 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral UNITED STATES 21620 4849 CLIFFS CITY ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 XNo If Yes Give Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL TECHNICIAN HEALTH CARE 12 4 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ JANET MACLAREN DARBY ELDRIDGE REEVES FENIMORE JOHNSON t. Page 1 and 2 shours of Health and Mr 19a. Informant's Name/Relationship (Type, Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4849 CLIFFS CITY ROAD CHESTERTOWN, MARYLAND 21620 ROBERT MORRIS HEWES III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ÷ 5 X Burial 2 Cremation 3 Removal from State Important: If any injury or 11/03/2012 CHESTERTOWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) PAUL'S CEMETERY . Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician da45 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy atter in the past 12 months? Month Day for 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director, Be examiner? Hospital: Other: 4 Nursing Home 5 Alesidence 6 Other (Specify) 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 50

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Jewett M. Harris Medical 4:50 PM 1,2014a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's

9. Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Year Days Min. Hours Director 257 70 5380 1 XM 2 | F 69 Aug 9, 1943 Georgia Usual Residence of Deceder show 10a. State 10b. County an "natural", or Itams 23a or 28a-f sho Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5286 W. Boniwood Turn 20735 United States within 72 hours efter deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Ves 2 No If Mes, Give Year or Dates. 1 Never Married 2 Married 2 Maryland 21215-0036 1884 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mantal Hyglene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) ä U.S. Air Force Retired U. S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgil Vascar Harris ba Philiola F1oyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Paga 1 and 2 she Department of Health an Important: If Item 27 is any Injury or other trau Gladys B. Harris (wife) 5286 Boniwood Turn, Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 4, 2012 Crematory Clinton MD 21. Sunature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria nes (1) tras Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to for as a consequence of: Examiner orone Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 #F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Year Pregnant at time of death Day 1 ☐ Yes 2 L 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rest Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of gause of 24a. Was an autopsy performed death? 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ၉ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -2-12 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 9,2012 Year Hoffman Jr. Donald Markwood 3:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 18615 Maugans Avenue Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 219-66-0375 Director 1 M 2 D F 57 July 18,1955 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantural must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 USA 18615 Maugans Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give "natural", or I Black, White, etc. 1 Never Married 2 Married 호 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end 2 should be filed within 72 Health end Mental Hyglene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Kiln Operator Brick Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Markwood Hoffman Sr. Wanda Missouri Teach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Hoffman (Wife) 18615 Maugans Ave. Hagerstown, MD 21742 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 e Depertment of h Important: If ite any injury or ot Page 1 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenlawn Mem. Park | Nov. 13,2012 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature I Funeral Service Li ^{22. Name and Address of Facility} Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 12/05 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The lew requires that the death certificate be executed physicien and s the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ettending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day ed by the e signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of us certificate has t. autopsy this certificate Tyes 2 DON 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Nesidence} \) 6 \(\text{\text{\text{Other}}} \) Other (Specify) ပ္ 1 Tes 2 🕽 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or-investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely To the I within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063593 who completed cause of death (Item 23a) (Type, Print) Williamsport, MD 2179 IW - 0 MA Wilson

State Registrar 31 Date filed (Month Day Year

P.O.

Harrohan, William November 2,2012 0800

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			Registrar 1. Decedent's Name (F	First, Middle, Las	st)		Cei	uncate	OIL	eaur		2. Date of De	Reg. No).		3. Time of D	eath
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	Medic Examin	_	4a. Facility Name (if no				•	4b. City,	Town, or	Location o	f Death	21070,		. County of De		0.00	
			Shady Gro		ntist Ho	ospital				ille			М	ontgome			
	Funeral		5. Social Security Num	2.11		7. Age (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	th y, Year)		irthplac ou <i>ntry)</i>	e (State or F	Foreign
	Director		426-26-172 Usual Residence of C		⊠ M 2 □ F	88	Yrs.				J	an. 8,	19:	24 <u>M</u>	S		
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	Maryle 18a-f	Director	MD	Montgo	mery	Pot	tomac									1 🗌 Yes 2	2 🔀 No
	a or 2		10e. Street and Number					10f. Zip	Code		•		10g. C	itizen of What (Country	?	
	h with	Funerai	8203 Post	oak Roa					854		1.0/0			USA			
	r Iten		 Marital Status Never Married 	1 2 X Marriad	Armed For		5. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ong n, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		14. Race - An Black, Wh			
21215-0036	within 72 hours after death with the Marylend glene. Her then "natural", or Items 23a or 28a-f show t. The Medical Examiner must be notified at	d by	3 Widowed 4		1 🔀 Yes If Yes, Give Year or Da		77	1 🗌 Yes	2 🔀 No	Specify:				Specify:Wh:	Lte		
Ď	hour natur	Completed		15. Decedent's E y only highest gr	ducation		16a. Dece	dent's Usua kind of wor	al Occupa	ation	t of workin	,	16b. l	Kind of Busines	s/Indus	stry	
2	nln 72 ne. hen "	틹	Elementary/Second		College (1-	4 or 5+)	Ìife. D	OO NOT use	retired)	umg mos	or working	9					
2	d with dygler ther t	BeC	17. Father's Name (Firs	at Middle Loot	4		Co	lonel		10 Moth	ar'a Nama	(First, Middle,		S. Arn	<u>ly</u>		
auc	be filed v entel Hyg ked othe ic event,	힡	William		Hanraha	ın						Kauslei		ourname)			
Maryland	1 end 2 should be fi f Heelth end Mentel Item 27 Is marked other traumetic ev	Н	19a. Informant's Name	e/Relationship (7	Type, Print)	-	19b. Mail	ing Address	(Street a					r Town, State,	Zip Coc	le)	
	d 2 sh elth el 1 27 le ir trau		Marlis K.	Hanraha	an/Wife		1	Post						0854			
Ę,			20a. Method of Dispos		Demoval from		Place of Disp emetery, cre	osition (Nan	ne of	_ [ate unk	20c. l	ocation - City	or Town	, State	
Ĕ	Pege ment c ant: If ury or		4 Donation 5			Ar]	lingto	n Nat: Cemet	iona	1			Ar1	ington.	_VA		
Baltimore,	permit. Pege Depertment of Important: If any injury or once.		21. Signature of Funer	ral Service Licen	Mahm		F	Panei	d Addres	ss of Facilit	ins I	uneral	Ho	me Inc.			
	40 = # 0		23a. Part 1. Enter the		- Linetiana bot a	ayaad tha daat								er Spri		MD 20	
			shock, or heart f	failure. List only									,		In	terval Betwood	een
- 1	nysician/ Medical		disease or condition resulting in death)	MAI	a. Dunto (cull r	es 100	Man	70	1140					+		
-	Examiner				5	cutl r or as a consequence	25 0	ration	P	neur	non	in					
		ner	Sequentially list cond if any, leading to intri- cause. Enter Underlyi	reciate	Due to (or as a consequ	uence oi):		Î								
	exacuted an end riel-transit	Examiner	Cause (Disease or in) that initiated events	ury	c	45 phas	i~								\bot		
		I	resulting in death) La	st		of as a consequence		êmen	ha	_							
8	physic the b	gi			d	attitue	140								上		
68	ding	Ž	IF FEMALE: 23b. Was decedent pr	reonant	23c. If yes, out			proteg						23d. Date of	delivery		
ŏ	eeth c e etter d for u	icia	in the past 12 mo	onths?	4 🔲 Preg	Birth 2 Teta nant at time of		☐ Ectopic ☐ Other (s _t		СУ				Month	Da	ay Ye	ear
<u>.</u>	the d by the techer	Physician/Medica	g 🗌 Unknown		g 🗌 Unkr												
Division of Vital Records, P.O. Box 68760	requires that the deeth certificate be e been signed by the ettending physicia should be deteched for use as the bur	ڇا	Part II. Other significa	ant conditions	contributing to d	eath but not res	sulting in the	underlying	cause gi	ven in Part	I.			use contribute		_	
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Ö	lew re has be e 2 sh	Completed										24a. Was	an opsy ormed?	prior	o comp	y findings avoletion of ca	
æ	ysician: The lew his certificate has t I director, pege 2 s		55 W	F. 1								1 Yes			Yes 2	□ No	
<u>ital</u>	siciar certif irecto	Be	25. Was case referred examiner? 1 Yes 2		Hospital:	Inpatient 2	ED/Outpati	2 [] D	Oth	er:			idonas	6 ☐ Other (Sp	nociful		
<u>ر</u>	a Phy ar this erel d	은 일	27. Manner of Death		28a. Date	of injury	28b. Time		28c. Injur	y at		8d. Describe			cciry		
on	anding ath. rr. Aft	ig	1 🗹 Natural 2 🔲 Accident	5 Pending Investigation	on	th, Day, Year)	injury	М	worl	Yes 2] No						
Visi	r Atti	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determined	, 28e. Place	of Injury - At h	ome, farm, s	treet, factor	y, office		1	28f. Location City or To		nd Number or te)	Rural R	oute Numbe	er,
۵	pital o		00. 0-46 1	¥0-46: DL	ysician: To the b	ant of my know	dadaa daath	occurred o	at the tim	e date and	d place an	d due to the	20100(0)	and manner as	stated		
	To the Hospital or Attanding Physician: The lew requires that the deeth certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicit completely filled in by the funeral director, page 2 should be deteched for use as the but	Medical	(Check 2	Medical Exar	ysician: 10 the bas niner, On the bas irse Practitionei	sis of examination	on and/or inve	estigation, in	my opini	on, death o	ccurred at	the time, date	and place	ce, and due to the	ne cause	e(s) and man	ner stated
	To the	≥	29b. Signature and tit		Ne N)	,	290	c. Licens	e number			29d. D	ate signed (Mo	nth, Da	y, Year)	
	12+1		•		y arv	N	D			06738)ovemb			
			30. Name and addres	1		se of death (Iter						:11+. A	Non	and z	385	0	
			Son A Joans 31. Date filed (Month,	ohn, MD		Medited legistrar's Signi				, 1		/ /	V				
	Sta Registi		NOV	05 201	2 Cens	we B	ture pa	ACTION A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 21 per hosp. g933 11/30/12 the Death - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEB Month Physician/ 2012 4:25 A M KALIEM REGINO HAMRICK Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY NATIONAL MILITARY MEDICAL BETHESDA CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 1 **X** M 2 □ F FEB 27 2012 MD 15 01 Usual Residence of Decedent ir then "naturel", or itams 23e or 28e-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County with the Maryland Director ROCKVILLE 1 X Yes 2 No MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 4701 COACHWAY DRIVE deeth 1 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married δ Maryland 21215-0036 hours efter 1 ☐ Yes 2X☐ No Specify Specify: UNKNOWN Il Hygiene. other then "naturei", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Be permit. Pege 1 and 2 should be fliad Department of Health and Mantal Hy importent: if item 27 is merked ott any injury or other treumetic evant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JIANNE LULANI TAYLOR MARCUS LAMONT HAMRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4701 COACHWAY DRIVE, ROCKVILLE. MD 20852 JIANNE TAYLOR/MOTHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETHESDA, MD HOSPITAL DISPOSITION JUN 6 2012 4 Donation 5 X Other (Specify) 22. Name and Address of Facility WALTER REED NATIONAL MILITARY 21. Signature of Funeral Service Licenses Leslie Wesson (per DVR) MEDICAL CENTER, BETHESDA, MD 20889 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ a. EXTREME PREMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami • Hospital or Attanding Physician: The lew requires that the deeth certificate be executed 24 hours after death.
• Funeral Director: After this certificata has been signed by the attending physicien and letaly filled in by the funeral director, page 2 should be detached for usa as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Physiclan/ 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav 4 Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of 1 Yes 2 No 1 ☐ Yes 2X No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No မြ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completaly fi 29a. Certifier ☐ Medical Examiner: On the basis of examipation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title dicertifier 29c. License number 29d. Date signed (Month, Day, Year) D0044634 OCT 4 2012

Registrar
DHMH 17 Rev 06-2011

State

JEFFREY R GREENWALD,

32. Registrar's Signature

30. Name and address of person who completed dause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL

BETHESDA

MD 20889

CENTER

12-06522 David Isreal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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4414 101041	1- For State Certificate of Death Reg. No.	_ (
Physician/ Medical Examine		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	\neg
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	
Director	215-58-5632 IX M 2 F 61 Yrs. Months Days Hours Min. April 12 1951 Foreign Country) DE	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
* "	DE Sussex Milford 1 X Yes 2 10e Street and Number 10f. Zip Code 10g. Citizen of What Country?	No
or items 23a or 28a-f shomust be notified at once.	10e. Street and Number 109 Manor Lane Apt. 116 10f. Zip Code 10g. Citizen of What Country? U.S.A.	
or items 233 must be not	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
s after dea ral", or is oiner mu by Ful	3 Widowed 4 Noivorced of Pates: Specify: White	
"natura Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Lisual Occupation (Give kind of work done 16b. Kind of Business/Industry	
5-0036 led within 72 hour led within 72 hour dygiene. other than "natu the Medical Exan Completed	Handyman Self-employed	
2 2 1 2 1 5 - 0 0 3 6 hould be filed within 72 hours after and Mental Hygiene. is marked other than "natural", after event, the Medical Examiner. To Be Completed by I	17. Father's Name (First, Middle, Last) Charles W. Jones, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Betty Mae Baker	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once TO Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Jones, Jr. (brother) 327 Cypress St. Millington, MD. 21651	b
re, MD I and 2 sho Health and Fitem 27 is	20a. Method of Disposition 1	
Baltimore, permit. Pages las Department of Her Important: If ite	Asbury Cemetery 11/14/12 Millington, MD.	
Ball permit Depart Impor	21 To at the of Funera Service Ucenster Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635	2
Physician	Approximate Inter fajlure. List only one cause on each line. Approximate Inter section on the death and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fajlure. List only one cause on each line. Approximate Inter Between Onset a Death	
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	-
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	-
red nsit	cause. Enter Underlying Cause (Utsees or kijury that initiated covents resulting in death) Last Due to (or as a consequence of):	
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760, cate be execut physician and he burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	- 8
the death certific the death certific by the attending I ched for use as the Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Other (Specify)	
the deatl the deatl by the atl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	13-1
P.O. res that signed be detay	1 Yes 2 No 3 Probably 4 V Unknow	٧n
Records, The law requires fricate has been sig page 2 should be	24a. Was an autopsy findings availe autopsy findings availe performed?	
I Rec	1 Ves 2 No 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	
f Vital Physician: Triple certification To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other: Scene	-
n of uding P th.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—trans-ledical Certification: To Be Completed by Physician/Medical E	2 Accident Investigation 3 Suicide 6 Could not be Aug 29, 2012 1645 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State)	Dity
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in belief in a decical Certific		
To the Ho within 24 To the Fu completely	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 26, 2012	
+	30. Name and address of person who completed cause of death (Item 23a)	
ms State	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registar's Signature	
State Registra		1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan	d / Depa	artmer <i>tificat</i>	nt of H	lealth a	and N	lental Hy	giene	201	2	387	21
			Registrar 1. Decedent's Name (First, Middle,	/ act)		Cer	uncai	e or L	eatri		2. Date of De	Reg. No	о.			
	Physicia Medic		Lois C.	Irvin							Month Octobe		9, 2012	ar 2	3. Time of D 12:30	
and the same	Examin	er	4a. Facility Name (if not institution,	,					Location o				. County of D			
-	<u> </u>		3310 N. Leisure 5. Social Security Number			ast birthday)		lver	Spri If Under		8. Date of Bir		ontgom		(Od=d= == 1	i
	Funeral Director		578-52-6855 Usual Residence of Decedent	1 □ M 2 □ F	73	Yrs.	Months	Days	Hours	Min.	(Month, Da March 2	y, Year)		Country	ace (State or F v)	-oreign
	and show Lat	5	10a. State 10b. County	-	10c. City	y, Town or Lo	cation							100	d. Inside City	Limits
	Maryla Be-f	Director	MD Mont	gomery	5	Silver	Spri	ng							1 🗆 Yes 2	2 ⊠ No
	with the I 23a or 2 ust be no	Funeral Di	10e. Street and Number 3310 N. Leisure	World Blvd	. #4]	L 7	10f. Zip	Code 2090	6			_	itizen of What USA	Countr	y?	
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene. item 27 is marked other than "natural", or items 23a or 28e-f show item 27 is marked other than "natural", or items 25a or 28e-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? ed 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		1	f Yes, spe	cify Cubar	spanic Origin, Mexican Specify:	, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W Specify: W	hite, et	c.	
Baltimore, Maryland 21215-0036	nin 72 hou ne, han "natu M. digal	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		+)	life. D	kind of wo O NOT use	rk done di e retired)	uring most		Ť	16b. i	Kind of Busine	ess/Indu	ıstry	18
12	d with	BeC	12	1		Admi	lnist	rativ	ve Of			-	<u>ederal</u>	Gov	<u>rernmer</u>	nt_
yland	d be file Mental H arked of stic ever	To B	17. Father's Name (First, Middle, La Malcolm V. Irvi	•		_					e (First, Middle, te I. H		Surname)			
, Mar	d 2 shou lath and n 27 is m er traum		19a. Informant's Name/Relationshi Audrey M. Fusco					,			al Route Numbe Silver			•	,	
ore	of He of He if item ir oth		20a. Method of Disposition 1♣ Burial 2 ☐ Cremation	3 Pemoval from State	20b. F	Place of Dispo	sition (Nar	ne of other place	e)		Date	20c. L	ocation - City	or Tow	n, State	
Ē	Page 1 Iment of I tant: If it	П	4 Donation 5 Other (Sp	pecify)	FOI	Ceme	terv				2012		entwoo			
Bal	permit. Page 1: Department of P Important: If its any injury or of	18	21. Signature of Edneral Service /	censee		F1 50	Name ar anci O Un	d Addres S J. ivers	s of Facilit Coll Sity	ins Blvd	Funeral	Hou	me Inc er Spr	ing,	MD 20	901
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	Medical Examiner		disease or condition resulting in death)	a. <u>Ovarian</u> Due to (or as a										+	2 yrs	
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	icate be executed physician and as the burid-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequ	uence of):								\dagger		
9	physi s the t	eg		d										\pm		
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	aldeath 3	Ectopic Other (s		у				23d. Date of Month		y ∂ay Yea	ar
P.O.	that the	by Ph	Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the u	nderlying	cause giv	en in Part	1.	23e. Did t	obacco	use contribut	e to the	cause of dea	ith?
ds,	quires en sigr ould be	ted b	End-Stage Rena	l Disease, D	iabe	tes					1 🗆	Yes 2	⊠ No 3 □	Proba	ıbly 4□ Ur	nknown
Division of Vital Records, P.O.	he law reite has be bage 2 sh	Completed											prior deat	to com	y findings ava	ailable use of
a	ian: T	Be C	25. Was case referred to medical examiner?	2 300 00 0				26. Pla	ace of Dear	th (Chec	k only one)	2 (32)		.00		
₹	hysic li dire	2	1 🗆 Yes 2 🖺 No	Hospital: 1 🔲 Inpatie	ent 2 🗆	ER/Outpatier	nt 3 □ D	OA Othe	r: 4 □ Nu	ursing Ho	ome 5 🖾 Resi	dence	6 ☐ Other (S	pecify)		
on of	nding Ph ath. r: After the	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig			28b. Time of injury	м 2	8c. Injury work¹ 1 ☐			28d. Describe 1	now inju	ry occurred			
Divisio	al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin				eet, factor	y, office			28f. Location (City or Tov			Rural F	Route Number	r,
_	n 24 hour n 24 hour ne Funera	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practitioner: To the	camination	n and/or invest	tigation, in	my opinio	n, death oc	courred a	t the time, date a	and plac	e, and due to t	he caus	e(s) and mann	ner stated.
	vithir Somp		29b. Signature and title of certifier					. License				29d. Da	ate signed (M	onth, De	ay, Year)	
			30. Name and address of person w										ober 3	/ ⊥ 9	<u> </u>	
	Sta	e.	Raymond A. Bass 31. Date filed (Month, Day, Year)	⊿32. Registra	ır's Signa	ture	-	Sil	ver S	Spri	ng, MD	2090)6			
	Registra		NOV 05 20	12	A	back	2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth 9. Birthplace State or Foreign **Funeral** Months (Month, Day, Director 1 X M 2 □ F Yrs strict of (olumbia 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Even cliner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Ś 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Sovernmen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ၉ (Ance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau AMMAINE 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CLOB lelson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 1 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 Yes 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5// 107 8:5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep.		,	2012	38723
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of De		3. Time of Death
	Physicia Medic		Earl Wilson Judy		Novembe	er 6, 2012 er	8:53 A M
	Examin	er	4a. Facility Name (if not institution, give street and number) Bowie Health Care Center	4b. City, Town, or Location of Death	l	4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th 9. Biri	thplace (State or Foreign untry)
	Director		235-36-6999 Usual Residence of Decedent 1 № 2 □ F 85 Yrs.		March 2	27, 1927West	Virginia
	ryland i-f shoried at	ctor	10a. State 10b. County 10c. City, Town or Lo	ecation			10d. Inside City Limits 1 X Yes 2 □ No
	the Ma or 28s e notif	I Dire	Maryland Prince George's Bowie 10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Co	<u>~</u>
	th with ms 23a must b	Funeral Director	12305 Millstream Drive	20715		U. S. A.	
9	ter dear or iter	by Fu	1 Never Married 2 A Married 1 V Voc 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
-003	ours af atural" cal Exa		Year or Dates. 1945-70	1 ☐ Yes 2 💢 No Specify:			White
215	in 72 h e. nan "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work O NOT use retired)	king		ne Department
d 21	ed with Hygien other ti ent, the	Be C	17. Father's Name (First, Middle, Last)	vestigator 18. Mother's Nan	ne (First, Middle,	of Agricult Maiden Surname)	ture
Baltimore, Maryland 21215-0036	d be fill Mental arked o	10	Leon Hulver Judy			Mongold	
Mar	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1.	ng Address (Street and Number or Rui 5 Millstream Driv e			
re,	ge 1 and it of Heal if item 2 or other		20a. Method of Disposition 20b. Place of Dispo		Date DOWN	20c. Location - City or	
timo	permit. Page 1 Department of Important: If it any injury or o once.		4 Donation 5 Other (Specify) Maryland	Veterans Cem. 11	/14/2012	<u>Crownsvill</u>	le, Maryland
Ba	permir Depar Impor any in			2. Name and Address of Facility Ro 6000 Annapolis Ro		. Evans Fund ie, Maryland	
	AMBORO - AM		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical	i i	Immediate Cause (Final disease or condition resulting in death) Coronary Artery Due to (or as a consequence of):	Disease			13
	Examiner	ř	Sequentially list conditions, b. Myocardial Infa	rction			1984
	uted d ansit	Examiner	Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to for as a concequence of your factors of the cause of the ca	gery			2001
	The law requires that the death certilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of): Hypertension				
3760	ficate by g physical formula for the last the last the last formula for the last formula for the last for the	Physician/Medical	_ d				
Box 687	requires that the death certificat been signed by the attending ph should be detached for use as th	ian/	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
M M	the dea by the a ached t	hysic	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)			
. P.O.	es that igned b	by	Part II. Other significant conditions contributing to death but not resulting in the Atrial Flutter S/P Ablation	underlying cause given in Part I.		obacco use contribute to Yes 2X No 3 □ P	
ords	been s	leted	Attial Indicer S/F Abiation		24a. Was	an 24b. Were au	topsy findings available
Records,	sician: The law certificate has t lirector, page 2 s	Completed			auto perfo 1 🗆 Yes	ormed? death?	completion of cause of
ta	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Descript 2 X EP/Outpation	26. Place of Death (Chec			1
o to	ig Physter this neral d	te: To	27. Manner of Death 28a. Date of injury Adapte Day, Your line of injury 28b. Time of injur	nt 3 🗆 DOA 4 🗆 Nursing H		dence 6 Other (Spec now injury occurred	ify)
sion	ttendir death. stor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f Location (Street and Number or Ru	ral Route Number
Division of Vital	tal or Arsafter al Direct		4 Homicide determined building, etc. (Specify)	oot, nastory, onloc	City or Tov		rai riodto riairibor,
	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the vithin To the compl	2	29b. Signature and title of certifier	29c. License number D0057994	nace, and due to	29d. Date signed (Month 11/6/2012	
	N/W		30. Name and address of person who completed cause of death (Item 23a) (Type,			11/0/2012	
Ì	D.		S. Ingo Ender, MD 128 Lubrano Dr.,	Annapolis, Maryla	nd 214	01	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 08 2012 32. Registrar's Signature	back			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00 a M LEO JONES November 2012 **Medical** 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death a Plata Medica narle Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 214-28-3972 86 Director 1 **X** M 2 □ F MAY 15, 1926 MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director 28a-f MARYLAND CHARLES LA PLATA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? c Completed by Funeral UNITED STATES 20646 6495 VALLEY ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Yes Yes 1 Yes 2 No Specify: If Yes, Give Specify: BLACK 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 8TH GRADE (0-12) College (1-4 or 5+) STATE HIGHWAY ADMIN. HIGHWAY TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY THERESA TAYLOR JONES CLINTON LEROY JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1509 NORTH POINT DRIVE, #303, RESTON, VIRGINIA 20194 BONITA JONES / DAUGHTER Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART CHURCH CEM. NOV. 10,2012 LA PLATA, MARYLAND 21. Separature of Funeral Service Accorded THORNTON JOHNSON MOO583 THORNTON FINERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ days disease or condition resulting in death) Medical Hypertension **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours all er death.
Funeral Director. After this certificate has tetely filled in by the fulleral director, page 2.5. autopsy performed death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV. Physician/ 2012 10:50A M Robert Lee Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Days 230 09 2489 1 🛂 M 2 🗆 F 90 **Director** 3/26/1922 VA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location death with the Maryland notified at Director Mitchellville 1 XYes 2 No MD Prince George' 10g. Citizen of What Country? 10e. Street and Number 0 ms 23a or Funeral 20721 1525 Kingshill Street USA items 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Examiner Black. White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any njury or other traumatic event, the Medical Examinane. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Completed 3 → Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Navy Exchange Plumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Susie Smith Robert Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1525 Kingshill St. Mitchellville, MD 20721 Robin Johnson/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home Signature of Funeral Service Licensee 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each ling Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (c **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Other (specify) Pregnant at time of death the a g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has bal director, page 2 si autopsy performe 1 ☐ Yes 2 ☐ No To Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Date of injury (Month, Day, Year) 28c. Injury at work? 1
Yes Certificate: 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After inpletely filled in by the funer iniury 5 \square Pending Natural Accident Investigation Suicide 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2 To the F complet

son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of po Hospital Drive

Cheverly,MD 20785 Demetrios James Catevenis

State Registrar (Check

only one) 29b. Signature and title

31. Date filed (Month, Day, Yea

12-08187

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ndreas Aguiler		1- For State		ate of Mary	and / Dep		Health				giene		201	2 38	3728	
Physici	_	Registrar 1. Decedent's Name									Date of Dea		Year	3. Time of D		
Medical Exami	ner	Jose	Andı		guilera		uez 4b. City, To	un orla	ontion of		Month October 2		ounty of Dea	1050 hi	rs	
		4a. Facility Name (if Peninsula R		n, give street and r	iumber)	1	Salisbu		Cation of	Deall			comico	ui		
Funeral		5. Social Security No	umber	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under		8. Date of Bir	th(MM/DD		irthplace (State		
Director		none		1 X M 2 F	2.	3 Yrs.	Months	Days	Hours	Min.	3/17/	1989	9 0	ount Mexi	CO	
any	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locati	ion							10d. Inside (City Limits	
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Maryland 28a-f shuw d at once.	Director	10e. Street and Num		et Stre			10f. Zip C	ode 2180	0.4		1	10g. Citizen of What Country? Mexico				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", ur items 23a nr 28a-f shu rraumatic event, the Medical Examiner must be notified at once.		10 10 P.	aryar		ecedent Ever in U	18 13 14/2				2 (Spec	ify Yes or No			erican Indian, B	lack	
eath w	Funeral	1 Never Marrie	d 2 Ma	Armed 1 Yes	If Y	es, specify	Cuban, I	Mexican, P	uerto Ri	can, etc.)		White, etc.		lack,		
after d	by F	3 Widowed		orced If Yes, Give You		Yes 2						eury.	hite			
hours "natu		15. Decedent's Ed			ade completed) (1-4 or 5+)	16a. Deceden during me	t's Usual O ost of worki	cupation ng life. D	n (Give kir O NOT us	nd of wor se retired	rk done d)		d of Business			
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medica	To Be	19a. Informant's Nar	ne/Relations	ilera I		19b. Mailing	Address	(Street a	and Numbe	er or Ru	al Route Nun	nber, City	or Town, Sta	te, Zip Code)		
MD id 2 shoulth and m 27 is aumatic		Jenifer	Eliza	abeth Ad Jaquez	uilera sister	1016	Mar	gare	et S	tre	et Sa	lisb	ury,M	id.218	04	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Impurtant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disp 1 X Burial 2	osition		206.	crematory or oth	ition (Name ner place)	or ceme	itery,	1/1	07201	2 ^{20c. Lo}	rango	or Town, State	ngo,	
Baltimore, permit. Pages I as Department of He Impurtant: If ite		4 Donation 5	Other Sp	ecity?	Pa	inteon							xicó	_		
Bal permi Depar Impu		21. Signatur of Fun	eral Service	icensee		伊田	TLTP		RINA nbia	LDI Bl	FUNE: vd.Si	RAL lver	SERVI Spri	CE,P.	A. 20910	
Physician		23a. Part I. Enter the failure. List only			caused the deat	h. Do not enter th	ne mode of	dying, su	ich as car	diac or r	espiratory am	est, shock	, or heart	Approxima Between 0	te Interval	
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Vita hysicia this cer ul direct	S = 0 1 ✓ Yes 2 No								ther ₄ []	Nursing I	Home 5	Residenc	e 6 Oth	er:		
- 4 . ~ 4	28b. Time of I	8b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot														
Division tal or Attendir rs after death. al Director: A	2328 hrs	et, factory, o				8f. Location (Street and	Number or F	Rural Route Nur	mber, City						
28 5E O Hollicos										ctory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1016 Margaret Street , Salisbury, MD						
e Hosp 124 hou e Fune etely fi		29a. Certifier	Certifying Pl	nysician: To the b	est of my knowle	dge, death occur	red at the ti	me, date	and place	e, and di	ue to the caus	se(s) and r	manner as sta	ated.		
To the within To the comple	Medical	29b/ Signature and		miner: On the basi and manner	s or examination stated.	and/or investigat		icense		ared at t	ne urne, date			onth, Day, Year	-)	
4	5		V . 1	· la · 11	1			D.C.M					per 31, 20			
•		30. Name and addre														
		Laron Locke		ssistant Medic				Street,	Baltimo	ore, Mi	21223	_				
Si Regis	_	31. Date filed (Monti	n, Day Year)	2012 32/	Registrar's Signa	ye far	Kent.									

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ November Henry Lawrence Knauer 3:51 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mallard Bay Care Center Dorchester Cambridge If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 217-36-0693 1 X M 2 | F 86 May 11, 1926 Maryland Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location must be notified at Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 21613 USA death with 3211 Ocean Gateway 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status ed other than "natural", or itelevent, the Medical Examiner Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2X No þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after white 1 Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) farmer agriculture Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked of rother traumatic even ည Josephine Peters John August Knauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813-2 Chesapeake Drive, Cambridge, MD John McGinnis p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>i</u> = 0 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: Il any injury or Dorchester Mem. Park 11/6/12 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastahie cell concer yehal Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at work?
1 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident 2 No Investigation within 24 hours after death

To the Funeral Director...

completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Rractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar SV

503

Registrar's Signature

CAMBRIDGE MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11/1/2012 Year Physician/ 0:38 Phillip Morgan Knapp Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Worcester Atlantic General Hospital CV 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Min **Director** 156 20 6624 Usual Residence of Dec 1**X** M 2 □ F O 82 8/12/1930 CA or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 🗆 Yes 2 🔀 No MD Berlin Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 30 Driftwood Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 3altirhore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AAI Aircraft Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Knapp Ruth Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Driftwood Lane, Berlin, MD 21811 Phillip A. Knapp 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/5/2012 1st State Crematory Millsboro, DE 4 Donation 5 4 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 00 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on sach line. Approximate Interval Between Onset and Death 0 Immediate Cause (Final Physician/ 1 de lun disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** CNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence)of) 0211 Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Knapp, Phillip N Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year sate has been signed by the a page 2 should be detached to 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - 2012 43 30. Name and address of person who completed cause of death (Item 23a) (Type Print) DN 10 DEXCUM IIID 73 COMM DE 13 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	_ FOI	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2012 38729
ı	Physicia		1. Decedent's Name (First, Middle, Last) Andrew G. Kalos	2. Date of Death Month 11/04/2012 Year 3. Time of Death 18 4 9 M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
المر			4824 River Valley Way	Bowie Prince George's
B	Funeral Director		5. Social Security Number 073-44-6548 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 60 Yrs.	If Under 1 Year
	ryland -f show ied at	Director	10a. State 10b. County 10c. City, Town or Lo	ocation 10d. Inside City Limits 1 □ Yes 2 👿 No
	r 28a notifi	Dire	Maryland Prince George's Bowie	10f. Zip Code 10g. Citizen of What Country?
	with the 23a cast be	iral	4824 River Valley Way	20720 USA
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1 Yes 2 V No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ★ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
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and 2	should be filed with h and Mental Hygien 7 is marked other traumatic event, th	To Be	17. Father's Name (<i>First, Middle, Last</i>) George P. Kalos	18. Mother's Name (First, Middle, Maiden Surname) Celia Theofiloyanokos
ızı	ould bould by mark marking			ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
M	d 2 sh alth ar 27 is er trau			Kingfisher Lane Lanham, Maryland 20706
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		4 Donation 5 Other (Specify) Resurrec	tion Cem. 11/10/2012 Clinton, Maryland
Balt	permit. Departi Import any inj	Į,	21. Signature of Funeral Schrice Licensee 2	2. Name and Address of Facility George P. Kalas Funeral Home PA 160 Oxon Hill Rd. Oxon Hill, Maryland 20745
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			Islander /glaster	140055-927 November 6,202
	5 W		30. Name and address of person who completed cause of death (Item 23a) (Type, Selvador Sylves Tev 300)	Hospital Drive Ceverly, Maryland
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			1. Decedent's Name	e (First, Middle,	Last)				-				2. Date of D	eath		V	3. Time of Death
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	Funeral Director		5. Social Security No. 217–28–980.	9	6. Sex	7. Age (In 81	yrs, last birth		If Under 1 Months [Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D January	ay, Year)		Cou	nplace (State or Foreign Intry) ryland
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936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ed 2 🗆 Marri	12. Was Dece Armed For 1 Yes If Yes, Giv Year or D	2 No	in U.S.	lf '		t of His	n, Mexican	, Puerto	cify Yes or No Rican, etc.)	-		k, White	
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	5		30. Name and addr	ess of person w	nho completed cau	se of death	(Item 23a) (T	ype, Pr	rint)	D	269	> 2	0 20		11	9	12
			Phyllis S	Chrein	25 6000	Exec	utive i	Blu	et. a	bek	k ville	m	11 20	852			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registraramend item#17-wchd-te-11-13-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Samuel Llewellyn 2012 0709 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical Ctr Salisbury Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Country) Director 220-34-5393 1 X M 2 ∏ F 89 4-8-1923 Jamaica Usual Residence of Deced ar than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No MD Somerset Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Upper Ferry Road USA 4735 S. 21822 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, end Mantal Hygiena. is markad other than "natural", or i Black, White, etc. 1 ☐ Yes 2 XNo 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Spec Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Campbell Soup Co 12 Line Worker injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba file end Mantal I မှ Alva Unk <u>Joseph Unk Llewellv</u>n and 2 should be Haelth end Ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Llewellyn/Son parmit, Page 1 and 3 Dapartment of Haelt Important: If item 2 any injury or other t 4735 S. Upper Ferry Rd, Eden, MD 21822 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other blace) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Direct Cremation, 11-13-2012 Dover, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in a cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final arborosea 100 Eclaro Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) daath cartificate be axecuted attanding physicien and for usa as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month bean signed by tha s should be datached P.O. or Attending Physician: The law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform rmed? 2 📉 N this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical of Vital funeral director, Be 26. Place of Death (Check only one) 1 Yes Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after daath. I Director: Aft od in by tha fur Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year, person who completed cause of death (Item 23a) (Type, Print) Borodulia vic Ave. Salisbury, MD 200 icholas M T'3 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 William M. LeCates November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICIMICO RENINSULA SAL 156414 Centu Social Security Numbe If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 218-12-1363 1XXM 2□F 96 Aug. 27, 1916 Delaware 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Exercitien in set be notified at 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 U.S.A. 3 E. Elizabeth Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married | SX Yes 2 □ No 1941-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 X Widowed 4 Divorced white Year or Dates 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 engineer railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ella Sirman Joseph W. LeCates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health 28883 Adkins Road William F. Hughes, Jr. (grandson) Delmar, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Importent: If ite eny Injury or ot cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stephens Cemetery 11-9-2012 Delmar, Delaware Signature of Fune at Service License 22. Name and Address of Facility Short Funeral Home uce 13 E. Grove Street Delmar, DE e diselse, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, an ire. List only one cluse on each line. 23a. Part 1. Enter the dise shock, or heart all re Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မြ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) ₩ 🗐 Naturai 5 \square Pending 1 Yes 2 No 2 Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 01C 005

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 08

2-08302 Ienrietta Kathy Lan	ding			Black Inde							ble. 2.0	***************************************	3873
	1- For State Registrar			Certifi	cate of	Death				Reg.	Street, And	e Boo	. 00,0
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Funeral Director	5. Social Security N 214-42-	7. Age (In yrs. last b		If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM.) Months Days Hours Min. March 13,						Foreign			
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and show	MD	Wico	mico	Del:	mar								1 X Yes 2 No
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th with	11. Marital Status	ad 2 Magrics		dent Ever in U.S.		s Decedent					14. Race - White		ican Indian, Black,

Baltimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death

Division of Vital Records, P.O. Box 68760,	
To the Hospital or Atteodiog Physiciao: The law requires that the death certificate be executed	
within 24 hours after death,	
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completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f show any injury or other traumatic eveot, the Medical Examioer must be couffied at coce.		MD		icomico		Lmar									1 X Yes 2 No
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To So	\$	29b. Signature and	title of certifie	and manner s	tated.		29c. Li	cense r	number	_		29d.	Date signed	(Monti	n, Day, Year)
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₩	1	30. Name and addre	ess of person	who completed caus	se of death (Item 23a	3)									
		Laron Locke		ssistant Medica		•	ıltimore S	treet,	Baltimo	re, ME	21223				[
	ate	31. Date filed (Mont	VPn YBn	2012 3 Re	egistrar's Signatrie	box	y J								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tal If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 SyF 0^M77017¹1915 97 MD **Director** 215-14-3929 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No MD Oueen Annes Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral with 1517 Dudley Corner Road 21651 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2X No Specify: Black Maryland 21215-0036 1 Yes 2 No Specify: 3 ¥Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Laborer Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Straudy Ming Arie Beatrice Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Adolphus Lee/Son 1517 Dudley Corner RD Millington, MD other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Place of Disposition of the place MT Pleasant U.M. Church Cemetery ö 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2012 Millington, Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral any 855 High STChestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Joites ? Physician 9 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 ed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 2 No g Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 3 Probably 4 Unknown Completed s been signated should be 24b. Were autopsy findings available 24a. Was an cate has t page 2 s performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to dica director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 읻 1 Inpatient 2 🕏 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (27. Manne 1 De 1 Natural 28a. Date of injury (Month, Day, Year) Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) cause of death (Item 23a) (Type, Print) 30. Name and address of perso 32. Regiskar's Signature 31. Date filed (Month, D State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#26 1-11/7/12, T.M., Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOROTHY LEAP Medical NOVEMBER 2012 11:14 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL AT EASTON EASTON TALBOT **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 . M 2 X F Months Hours Min. nth, Day, **Director** 85Yrs. <u>212-24-3618</u> JUNE MARYLAND Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 GREENWOOD AVENUE UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces? þ Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married If Yes, Give Year or Dates 3X Widowed 4 □ Divorced 1 Yes 2 XNo Specify: Specify: WHITE Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ပ္ BRESTLE A. RUPERT ELIZABETH BENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tu once. CAROL START / DAUGHTER 22245 TOLCHESTER BEACH ROAD CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PAUL'S CEMETERY 11/08/2012 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MALRYLAND 21620 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Onset and Death robable Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 1 Yes 2 2 9 Unknown cate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🖊 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 2 No After this certificate Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA ■ 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifie CRNP 8 R111187 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3683 Choptank Rd. Preston, MD. 2165T Im Arlene Stevens

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Da

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32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Franklin Laign Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland Western MD Regional Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-48-9491 **Director** 64 1 🕅 M 2 🗆 F 05/17/1948 Maryland Usual Residence of Deced 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director notified LaVale MD Allegany 28a-1 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code ò ms 23a or 10g, Citizen of What Country? Funeral 21502 USA 27 Buchanan Avenue items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or 1 X Never Married 2 Married þ Yes, Giv Page 1 and 2 should be filed within 72 hours after 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify. Completed White Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Hospital Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ၀ Rupert Franklin Laign Marjorie Greta Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coge 245 Maple Avenue, Box 6, Keyser, WV 26726 t of Health a Rachel Loya / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ō Department of Important: If any injury or once. Cumberland Crematory 11/09/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, n ture of Funeral Service L 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ 4nox16 disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to joi as a consequence of) attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The 24 hours after death. Funeral Director. After this certificate I 1 🗌 Yes 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 🔑 No ျ 1 ₱ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Matical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of

30. Name and address of perso who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

10033286

625 Kent Avenue, Cumberland, MD

29d. Date signed (Month, Day, Year)

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me, g934 12–17–12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ arie Koxann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WMHS Regional Ctr. Allegan Medical umberland 5. Social Security Number 9. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 220-26-9628 Hours (Month, Day, Year) Director 1 🗌 M 2 🔀 F 82 10-7-1930 or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 23a or 28a-f sh ust be notified a Bedford Hyndman 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 273 Church 15545 Examiner must USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.

It is marked other than "natur traumatic event, the Medical [15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk KETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willison Leroy Elizabeth HV5 band 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 273 Church St Po Box 211 HYNDMAN PA Lafferty permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr m. Homer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔀 Removal from State HYNDMAN CEMETERY 11-16-2012 HYNDMAN PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARVEY H. ZEIGLER F. H. INC Clarence St. HYNDMAN PA MIMI 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Intracerebrot Immediate Cause (Final Onset and Death Physician/ Herworthere disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) burial-transit KAMINER and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 No Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Verm 1 Yes 2 No 3 Probably 4 miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 1 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 FR/Outpatient 3 IDOA pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending Natural work Accident 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the I within 2
To the I complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1/14/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg 21532 Jesus Tan Broadway MO 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Sandra T. Maddox 11:09 AM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomi Hospice at th 11554 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Davs Hours Min Country) **Director** 217-78-9171 1 🗆 M 2 🗶 F 50 1-20-1962 MD 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Salisbury 1 ☐ Yes 2X No MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 812 East Church Street USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Completed by Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Sped lack 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Meat Wrapper Meatland Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Anna Maddox Roosevelt Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra MD 21871 Mary A. Maddox/Mother 28753 Fairmount Rd, Westover, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Wesley Cem 11-10-12 Westover, MD f Funeral Service Lic Gee 21. Signature 22. Name and Accress of Facility 917 W. Isabella St. Salisbury, MD 21801 Funeral Home 23a. Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ lano is disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate executed Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated based by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: No No in 24 hours after deam.
the Funeral Director: After this c 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred at the Natural 5 Pending injury Accident M 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 1)63199 3/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HB 3 910 TOGESH VOHRA ENSTERN

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e per FH FCHD TM 11/7/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 G. Matlock 12:07p Nov. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 403 A Magnolia Avenue Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min Country Director 578-36-9745 Yrs 89 Jan. 18,1923 Virginia Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No Frederick Frederick Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 A Magnolia Avenue 21701 United States 403 Magnol 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Mamied 2 Married Completed by ☐ Yes 2 No 1 Yes 2 No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home and Mental Hygie is marked other Be J. Marylat.

J. Marylat.

J. J. Marylat.

Department of Health and Mental Humportant: If item 27 is marlany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ George Harris Minerva Hargraves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Ray Matlock / Son 202 Wellesley Court, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leaf Cemetery 11/10/2012 Silver Rose Hill, Virginia 21. Signature of Juneral Service Lice 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complica-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav been signed by the s should be detached Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 2 🗆 No 2 54 N within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 📈 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatuje and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) malla D27544 November 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Anthony Vitarello MD 180 Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Kent 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F MI Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Black 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 000 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother errance 3 WD21620 00d4 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Chestertown 10/2012 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice 21. Signatur 22. Name and Address of Facility High tertown MD 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Mattilar Branchesenic Careinon (squamous cell) Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has t completed filled in by the funeral director, page 2 s autopsy MOORLIDID ance 1 ☐ Yes 2 ☐ No 2 No 25. Was c referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No. မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number

Registrar

223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ dettber ANN LARRIMORE MORRIS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tal be If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 218-34-9173 1 M 2 X F AUG. 3.1937 MARYLAND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene.
Important: If item 27 is marsed other than "natural", or items 23a or 28a-f show any injury or other traumatice event, the Medical Examiner must be notified at once. 10a, State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits MD TALBOT QUEEN ANNE 1 🗌 Yes 2 🕱 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13441 DULIN ROAD 21657 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Specify. WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TELEPHONE OPERATOR COMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES BUCK LARRIMORE ERMA POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH MORRIS/SON 31655 CLARKS WHARF ROAD, TRAPPE, MD 21673 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State NOV. 4 ☐ Donation 5 ☐ Other (Specify) 2012 CHESTERTOWN, MD 21. Signature of un rai Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Eudocardi Hs bacterial Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 No 2 🗷 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: မှု 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident М Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined **Medical** 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar JOHN BOTSIS, M.D., 219 S. WASHINGTON ST., EASTON, MARYLAND 21601

31. Date filed (Month, Day, Year)

32. Bégistrar's Signature,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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10-27-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2012 1:35 P JOHN GLENN MESSICK, SR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ARCADIA ASSISTED LIVING CHESTER QUEEN ANNE'S Social Security Number . Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. Hours APR. 11, 1920 1 X M 2 🗆 F DELAWARE Director 220-01-6367 92 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director QUEENSTOWN MD QUEEN ANNE'S 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21658 654 DEL RHODES AVENUE Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed WHITE Year or Dates 1945-1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **FARMING FARMER** -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatione. ပ MAE E. BROADRUP FRED M. MESSICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 MARLBOROUGH ROAD, QUEENSTOWN, MD 21658 MICHELLE WILLEY/GRANDDAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) NOV. WOODLAWN MEMORIAL PARK Donation 5 Other (Specify) 2012 EASTON, MD Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, LIBERTY ST., CENTREVILLE, MD 21617 Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Myocardeal disease or condition resulting in death) DERTENSTON Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Que to for as a consequence of ARTERIOVAS CUCAR Desease Peripheral that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown Unk*n*own Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 2 No 25. Was case referred to medical Be 26 Place of Death (Check only one) examiner? Hospital 1 Yes 2 僅 No ၉ 1 Inpatient 2 ER/Outpatient 3 I

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Division of Vital Records,

To the Hospital or Attending Physician: The law

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		Injury a			Describe how inj					

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her (Specify) Citize Hour

rred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Street Chester four

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VR-

28a. Date of injury (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

Investigation

determined

6 Could not be

27. Manner of Death

Natural Natural

29a. Certifier

Accident

Suicide 3 ☐ Sulciue 4 ☐ Homicide

32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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State Registrar

Physician/ Medical Examiner

Physician/

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Director

Funeral

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Examiner

Funeral

Director

er then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

Page 1

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disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Be examiner?
1 Yes 2 No မှ 1 Inpatient 2 PER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifie 29c. License number

7503 Surratts Road Clinton, Maryland

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Registrar

B. park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Oyedele//MD

Kara

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward November 4. 2012 James Mills, Jr. 8:50A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 3830 Leafcrest Court Dunkirk **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 578-46-5399 4/30/1934 **Director** Indiana 1 🕅 M 2 🗆 F 78 28a-f show with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 X No Marvland Prince George's Clinton ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8305 Schultz Road 20735 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Black, White, etc. 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Contractor Self-employed Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and ...
of Health an...
's item 27 is mars...
'x traumatic ev ည Bertha M. Sidebottom James Edward Mills, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3830 Leafcrest Court, Dunkirk, MD 20754 Cindy Sue Bulka/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donaron 5 □ Other (Specify) cemetery, crematory or other place St. Barnabas Ch. Cem 11/15/2012 Temple Hills, MD 22. Name and Address of Facility George P. Kalas Funeral Home ales 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Glioblastoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the at d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been si rector, page 2 should 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes 2 🛛 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 2 💢 No Other Daughter's ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 X Other House 27. Manner of Death e Hospital or Attending Pl 24 hours after death. Funeral Director; After the 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge destinous med at the time. Sate and place, and due to the cause(e) and mainler as stated

State

Registrar

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Raymon A. (Noble 31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signat

DHMH 17 Rev 06-2011

238 Merrimac Ct., Prince Frederick, MD

29c. License number

D17324

29d. Date signed (Month, Day, Year)

11/6/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:15 Malberg Jonathan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 578-60-1978 1 🛛 M 2 🗆 F 67 Yrs. 08/12/1945 Washington DC Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland Washington 1 Yes 2K No Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9341 Childacrest Drive U.S.A. 21713 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fire Investigator Fire Protection other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Ralph Malberg Julia Dowdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah B. Malberg / Wife 9341 Childacrest Drive, Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 11/10/2012 | Hagerstown, Maryland 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Rest haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ A CUT & HYPOXEMIC RESPIRATION FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONI Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). THIROMBO CYTO PENIA the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician MENINGIONA by Physician/Medical DF HISTORY Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of has autonsv performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director. After this certificate is the Funeral Director. After this certificate is the Funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 PInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1- Natural work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

JW-5

Registrar

DHMH 17 Rev 06-2011

State

MD

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32. Registra#s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Flo2012 :54AM Beuna Moody Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Montgomery <u> Hospital</u> If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days **Director** 210-12-0035 1 🗌 M 2 🕱 F 89 Usual Residence of Decedent Aug 31 1923 MD or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland at Director be notified 1 Yes 2 No MD Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 20832 **USA** 18301 Georgia Ave. Apt items ? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or by 1 Never Married 2 Married 1 Yes Mo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: white Completed 3 ₩ Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 homemaker own home traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jennings Stair Martha (Reese) Stair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Susan Collins 20400 Powell Farm Pl Brookville MD 20833 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Gremation 3 - Removal from State 4 Donation 5 Dother (Specify) Restlawn Mem Gar 11/16/2012 LaVale MD 22. Name and Address of Facility 21. Signature Funeral Scarpelli Funeral Home, P.A. 108 Virginia Avenue Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or friend failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or Indition resulting in death) Onset and Death Physician/ sever sepric Medical Due to (or as a consequence of) **Examiner** meumonia Sequentially list conditions, Examiner if any, leading to immediate Die to (or as a consequence of): atrial fibrillat the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Enpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of D74516 November 13, 2012 10

Registrar
DHMH 17 Rev 06-2011

State

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inco Phillip Dr. Olney, MD

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.I d.,pt.II,25,27,28a-f,per me.g935 1-8-13 SM State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8,20 Cornwell Moore Lois Medical Examiner acility Name (if not institution, give street and number) ounty of Death 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 81 229 34 3472 1 □ M 2 🖁 F Director July 29, 1931 <u>Virginia</u> Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits at Completed by Funeral Director must be notified 1 🗆 Yes 2 🄀 No 28a-f Upper Marlboro . Prince George's Maryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a 20772 10600 Wyld Drive United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Examiner Armed Forces ō 1 Never Married 2 Married Yes 2 No 1 Yes 2 No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Services 12 Bookeeper marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Cornwell Dinah Davis traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a <u>10600 Wyld</u> Drive, Upper Marlboro, MD 20772 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Ralph W. Moore (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Nov 4, 2012 Clinton. MD Crematory 21. Signature of Funeral Ser i e licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Douis Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. COMPL Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? igned by the atte Pregnant Unknown Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed Chronic Lymphocytic Leukemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform ul or Attending Physician: The later death.

Director: After this certificate P Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical funeral director, Division of Vital Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 MInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred work? 5 Pending subject fell 10-23-2012 2X No 2 X Accident Investigation 6 Could not be filled in by the unk 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Doctor's Office** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11345 Pembrooke Sq. Ste: 105 Waldorf, MD. determined Ste: 105 within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of 29d. Date signed (Month, Day, Year) 299 Lisen 57 Wm \$ 50 883 206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VATHI 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 26 per DVR C934 12/5/12 dk State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Registrar Reg. No. 2 0 2 3 8 7 5															
			State amend #19a Per FH G943 121.0072012 3H Registrar Certificate of Death							Reg. N	0.21	12	3875		
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	Examin	er	4a. Facility Name (if not institution, give	•			4b. City, To			f Death					
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	s filed within 72 hours effer death with the Meryland ital Hygiene. So of them 23a or 28a-f show event, the Medical Examinar must be notified at		10e. Street and Number			10f. Zip Code							Citizen of V		•
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		e Completed by	11. Marital Status	Armed Forces?	1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						 Race - American Indian, Black, White, etc. 		
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			2 Firefighter/ Paramed						amed					o. Govern.	
pu			17. Father's Name (First, Middle, Last)					- 1			ame (First, Middle, Maiden Surname)				
7			Tony Thompson								ly May				
Maryland			19a. Informant's Name/Relationship (7) Robert J. Mascard		19 P	b. Mailing	Address (S Box 2.	130	nd Numbe	r or Rura Shon	n Route Number	er, City o l and	or Town, Si 2176	ate, Zip C 55	Code)
	Heat Heat ther	П	20a. Method of Disposition	7 110520110	20b. Place				1		Date		Location -		wn State
Baltimore,		П	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemet Cremat	ery, crema	atory or other	er place			3/2012	l			ryland
Ħ	투구한국		21. Signature of Funeral Service Licens		prenac										ly FH, Inc.
Ä	Departing the policy of the policy in policy i		Xuanto RC	thomas											MD 21043
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P	Pnysician	5 3	Immediate Cause (Final disease or condition	APENOC	ARCIAL	OM 0	DE	DAIR	MOINS	N F	POIMAR	V			Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions,	h											
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		Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										\dashv		
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89	leath certifi e attending d for use e	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d			. Date of delivery		
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	Hospital 24 hours : Funerei I stely filled	Medical	29a. Certifier (Check (ed. use(s) and manner stated.			
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and 29b. Signature and title of certifier 29c. License number							ace, and due to	due to the cause(s) and manner as stated.							
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Amend #20b per FH G934 12/5/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\overset{\text{Month}}{10}$ Day 201^{yea} Massie 7:45 P George Elwood 31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 627 Frederick Street Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Hours 218-50-4068 Director 1 🛂 M 2 🗆 F 66 Oct. 23, 1946 Maryland Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🏝 Yes 2 🗆 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 627 Frederick Street 21740 U.S.A. ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) or than ". $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) alth and Mental Hygien 27 is marked other to traumatic event, the Supervisor Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ John Massie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5629 Lockridge Loop Unit 1, Fort Hood, TX 76544 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Albert Massie / Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/15/2012 Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 🚧 1601 Pennsylvania Avenue, Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. ter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the bunal-tran Due to (or as a consequence or Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the af Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Winner Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ To the I within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Day Juanita Poff Nicholson 2012 2:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 577-22-1137 90 Director 1 □ M 2 🗓 F 02/08/1922 Virginia or 28a-f show notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland **Funeral Director** 1 Yes 2 X No Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 9 items 23a or ner must be r 717 Pioneer Trail 20657 United States and 2 should be filed within 72 hours after death ' Health and Mental Hygiene. tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🌠 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Paper Products Office Manager 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Claudine Elizabeth Page Clyde Arthur Poff, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11439 Vale Spring Trail, Oakton, Virginia 22124 Joan Zottig - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o once, 💹 Burial 2 🗌 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery | 11/12/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CARDIO MYO BATTY ONCESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending properties as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed acchanne 1 Yes 2 No 1 Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 24 hours after death Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ha

To the Fune

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRN 5 Hosp talk

State Registrar

DHMH 17 Rev 06-2011

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32. Registrans Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:50 AM Shimek O'Brien Josephine November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dorchester Hurlock 306 Main Street Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) Country) **Director** 176-18-6954 1 🗆 M 2 🛛 F 89 Nov. 25,1922 Maryland Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Hurlock Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21643 306 Main Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Manufacturing Check Inspector 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Barbara Navratil John W. Shimek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5631 Cedar Grove Road, East New Market MD 21631 Theresa M. Shimek/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation Beulah, Maryland 11/7/2012 MD Veterans Cemetery 5 Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary disease or condition Medical resulting in death) Due to (or as a conse conf): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed peen has Certificate: To Be

Division of Vital Records, P.O. Box 68760 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di

Medical

State

Registrar

-		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed?/ 1 □ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Death (C	Check only one)
examiner? 1 Yes 2 No	Hospital: 1	ng Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigati		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28e Diace of Injuny - At home farm etreet factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place	ce, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of

10057040

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREET, CAMBRIDGE MI) 105 100 AURURA BRENDON

31. Date filed (Month, Day, Year) NOV 87 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Ralph Palmer Jr Η. November 8,2012 2345 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 578-78-7564 1 X M 2 D F 55 March 29,1957 Usual Residence of Deceden Wash., DC item 27 Ia marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD PG Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Jarvis Avenue 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Completed by 1 Never Married 2 Married 2 XNo ☐ Yes 1 ☐ Yes 2 X No Specify: and Mental Hygiene. Ia marked other than "natural", If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Specify: Year or Dates Black 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walker Ralph H. Palmer Sr Doreathea permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Ia marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2309 Kenton Place Doreathea Brown/Sister Temple Hills

20b. Place of Disposition (Name of cemetery, crematory or other place) MD. 20a. Method of Disposition 20c. Location - City or Town, State 11/1^{Date}/12 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H 3910 Silver Hill Rd., Suitland, MD. 20746 2/a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No certificate has been signed by the a lirector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatb? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 \(\text{No.}\) 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Signature and title of certific License number 29d. Date signed (Month, Day, Year) 20 25m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

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of Vital

Division

32. Registrar's Sig

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 20a,c per fh g933 11-30-12 vt State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 = State Registrar amended item 20-te-wchd-11-12-illicate of Death Decedent's Name (First Middle 2. Date of Death 3. Time of Death Physician/ 0 arsons 2012 Medical 4a. Facility 4c County of Death Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Valisbur 10spice at the 1 com 100 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) Country) 215-38-1335 1**X** M 2 □ F **Director** 71 12-15-1940 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD Worcester Pocomoke 10f. Zip Code or 10e Street and Numbe 10g. Citizen of What Country? items 23a Funeral 912 Ocean Highway 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Spe White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement 12 Correctional Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret S. Jordy Howard L. Parsons, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA 23301 Ameesha Hall/Fiancee 24280 Oyster House Rd, Accomac, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Deponation 5 Other (Specify) Unk Unk John Wesley Cem.Unk Unk Westover, Md 22 Name and Address of Facility 917 W. Isa Bennie Smith Funeral Home Salisbury, 21. Signature of Funeral Service Licensee Isabella St. MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ HRONIC TRUCTIUR PULMOWARY DISKASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MALIGNANT CARCINOWA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day Year 2 No n signed by the a g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, been signature should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 2 10 1 🗌 Yes 1 Yes After this certifical funeral director, p Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2/1 No Other: HOSPICIZ 1 Tyes 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 욘 28c, Injury at work? 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated -Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 00053410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year 02° Clara Nov. 12:00 AM Paquette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16 Maryland Ave. Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 556-74-5214 Director 95 1 M 2 X F 02/20/1917 CA Usual Residence of Dece show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 28a-f s MD Anne Arundel Annapolis 1 X Yes 2 □ No 10 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country Funeral 23a 16 Maryland Ave. 21401 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White Specify 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmatic. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Priess Marie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Krauss (daughter) 16 Maryland Ave. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 11/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Light 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physicians dvan disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death the Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖪 No Other: ျှ ER/Outpatient 3 DOA 4 \(\sum \) Nursing Home 1 Inpatient 2 I 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 / Natural Natural Accident 5 Pending n 24 hours after death.

Funeral Director: Ailetely filled in by the fu 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

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complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o

Registrar DHMH 17 Rev 06-2011

State

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Dr. Frederic Karkowski 139 Old Solomons Island Rd Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08 2012

29c. License numbe

0054903

29d. Date signed (Month, Day, Year)

2012

			Plea	se Type or						_		_	
		For State Registrar		State	or iviaryiar		irtment of l tificate of		and iv	лептаг ну	giene Reg. No	0010	29759
		Decedent's Name	e (First, Middle	, Last)						2. Date of De	ath		3. Time of Death
Physicia Medic		Perry Pr	osper							Novemb	er 2	201 ^{Year}	10:25 p ^M
Examin	er	4a. Facility Name (if			mber)		4b. City, Town, o		of Death		4c.	County of Dea	
Francis		Genesis 5. Social Security No		Care 6. Sex	7. Age (In yrs.	ast birthdav)	LaP1at	I a If Under	24 Hrs.	8. Date of Bir	th	Char1	es thplace (State or Foreign
Funeral Director		438-64-48 Usual Residence of	51	1 🗽 M 2 🗆 F	6		Months Days	Hours	Min.	March March	24, Year)	1945	MD
laryland 3a-f shov ified at	Funeral Director	10a. State MD	10b. County Char	les		y, Town or Loc Plata	ation						10d. Inside City Limits 1 √2 Yes 2 □ No
the N a or 28	Į Dir	10e. Street and Nun	nber				10f. Zip Code				10g. Cit	izen of What Co	ountry?
n with	nera	1 Magnoli	a Dr.				2064	<u> </u>				USA	
Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If fire Z7 is marked other than "naturaly", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 x x Never Marri 3 □ Widowed		Armed F	2 🗌 No ve	If	Vas Decedent of H Yes, specify Cub ☐ Yes 2 🔀 No	an, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: W.	
hour 'natur	olete	Sne		nt's Education st grade completed			ent's Usual Occup ind of work done		t of work	ina	16b. K	ind of Business	/Industry
within 72 rgiene. ner than '	Completed	Elementary/Seco			1-4 or 5+)	life. DO	norweined, NOT use retired, narketer					Sales	
d be filed Mental Hy arked oth tic event	To Be	17. Father's Name (I Unknown	First, Middle, L L	ast)				18. Moth Unki	ier's Nam 10WN	e (First, Middle,	Maiden :	Surname)	
nd 2 shoulk ealth and M n 27 is m e e r traum a		19a. Informant's Na Kim Sine					g Address (Street Port Toba						
Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disp 1 🔀 Burial 2 4 🗆 Donation	Cremation	3 ☐ Removal from	n State	cemetery, crem	sition (Name of patory or other plans Cem.	ce)		Date 4/2012		ocation - City or Ltenham	
permit. Page Department of Important: If any injury or once.		21. Signature of Fur	neral Service L	icensee		0/15	Name and Addre		TIC				al Home,PA
Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or conditio resulting in death)	rt failure. List c (Fin <i>a</i> l	nly one cause on e		th. Do not ente	r the mode of dyin	ng, such <i>a</i> s	cardiac o				Approximate Interval Between Onset and Death
Examiner	er	Sequentially list co	onditions,	b. TYE	or as a conseq	siabed	es Me	Wit	درح				inknow
xecuted n and al-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying injury s	с	(or as a conseq	·							
cate be e physicial s the buri	edical			L d	200								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live	itcome of pregna Birth 2 Fet gnant at time of known	aldeath 3 ⊑	Ectopic pregnan Other (specify)	су				23d. Date of de Month	elivery Day Year
ires that the signed by the detail	by	Part II. Other signif	Der La	ns contributing to	death but not res	sulting in the u	nderlying c <i>a</i> use g	iven în Part					o the cause of death? Probably 4 Unknown
sician: The law requ s certificate has beer director, page 2 shou	Completed	Perip	heral	Vasce	eler a	alise	950			24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings available completion of cause of
ian: Ti rtificat ctor, p	Be C	25. Was case referre	ed to medical				26. F	lace of Dea	ath (Check		ZLINI		5 2 1110
hysic his ce al dire	은	1 🗆 Yes 2 🛚	No.		Inpatient 2		t 3 🗆 DOA Oth	ier: 4X N	lursing Ho	ome 5 Resi	dence 6	Other (Spec	cify)
ending P sath. or: After the	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pendin Investig	gation	e of injury nth, Day, Year)	28b. Time of injury	28c. Inju wor M 1			28d. Describe I	how injun	y occurred	
tal or Atturs after de al Directo led in by 1		3 ∐ Suicide 4 ☐ Homicide	6 ∐ Could determ	ined 28e. Place	e of Injury - At he ling, etc. <i>(Specif</i>		et, factory, office			28f. Location (City or Tox			ural Route Number,
In the Hospital or Attending Physician: within 24 hours after death as a fare death To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2	Medical E	Physician: To the xaminer: On the ba Nurse Practitione	sis of examination	n and/or invest	igation, in my opin	ion, death o	ccurred a	t the time, date a	and place	, and due to the	cause(s) and manner stated.
Noth Vith Corr		29b. Signature and	Hant	Carros			29c. Licens	e number	30		29d. Dat	te signed (Mont	h, Day, Year)
12 20		/ 4	7	1.	se of death (Iten	23a) (Type, R	winder	30	6	abbr	(M	D 36	Look .
Stat Registra	te ar	31. Date filed (Mont.	h, Day, Year) OV 0 7	2012	Registrar's Signa	g. Spa	Ne .						

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			1 State Amend 20b per Finte of Mary	/land / Depa	artment of He	alth and N	1ental Hyg	iene		
			Registrar DOR, 11/5/12, LDB	Cer	tificate of De	eath	R	eg. No.	12	38/59
	Physicia	n/	1. Decedent's Name (First, Middle, Last) SHIRLEY RU	ARK			2. Date of Deat	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ncation of Death	October	4c. County o	012	<u>6:22 a ^M</u>
	Examin	er	2036 Dailsville Road		Cambri				rches	ster
7	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year I	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthpl	ace (State or Foreign
	Director		213-26-1321 1□M2 ▼ F 8	1 Yrs.	Worth's Days	Hours Will.	Dec. 31		Mar	yland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	eation				10	Od. Inside City Limits
0	larylar 3a-f s ified	ecto	MD Dorchester		Cambr	idge				1 ☐ Yes 2 🛣 No
2	or 28	٦	10e. Street and Number		10f. Zip Code		1	l0g. Citizen of WI		
3	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	2036 Dailsville Road		2	1613			USA	
7	death item ner m	Fur	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race	- America , White, et	
330	after al", or xami	d by	1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give	1	☐ Yes 2 🗓 No	Specify:		Specify:	whi	
9500-61212	hours natura ical E	Completed	15. Decedent's Education		ent's Usual Occupation			16b. Kind of Bus	iness/Ind	ustry
בוע	in 72 e. nan "r	duc	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	rind of work done dun O NOT use retired)		ng			·
	with ygien her th		10		homemake				home	
yland	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 25a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Henry Fultz		1	8. Mother's Name	e (First, Middle, N 1 Bacon	faiden Surname)		
	should be filed with h and Mental Hygien 7 is marked other tr traumatic event, th		19a. Informant's Name/Relationship (Type, Print)	405 Marilla	g Address (Street and			City or Town Str	to Zin C	adal
Mar	12 shoulth an 27 is rtrau		Donald S. Ruark husband		Dailsvill				2161	•
e,	1 and of Hez item		20a. Method of Disposition	20b. Place of Dispos		11 0		20c. Location - 0	City or Tov	vn, State
Ē	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	orchester	Mem. Par		9/12	Cambri	.dge,	MD
baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en	Ę	21. Signature of Funeral Service Licensee	7(Name and Address	of Facility Tho St Can	mas Fun	eral Hom MD 216	е Р. 13	Α.
			23a. Part 1. Enter the disease, or complications that caused the							Approximate
NG.	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	STAGE	COPI					Interval Between Onset and Death
· Marie Control	Medical Examiner		resulting in death) a. Due to (or as a co						\top	
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a co	nsequence of):					_	
	rted d ansit	dical Examiner	cause. Enter Underlying Cause (Disease or Injury	, ,						
	execu an and rial-tr	I Ex	that initiated events c. Due to (or as a co	nsequence of):						
00	ate be executed bhysician and the burial-transit	dica	d						+	
000	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of p	regnancy						
XOD DOX	ath ce attend for us	cian	in the past 12 months?	JFetal death 3 ∟	Ectopic pregnancy Other (specify)			23d. Date Mont		ry Day Year
Ö	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	1 Yes 2 No 4 Pregnant at tim g Unknown 9 Unknown		(4)					
Γ. Ο	that t ned b e deta	by P	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause given	n in Part I.	23e. Did tob	acco use contrib	oute to the	e cause of death?
ď,	quires en sig ould b	ted					1 🗆 Ye	es 2 No 3	Prob	ably 4 🗌 Unknown
ecords,	aw recast be as be	ple					24a. Was ar	y pr	ior to com	sy findings available apletion of cause of
ě	hysician: The law r his certificate has b il director, page 2 s	Completed					perform 1 Yes		eath?	2 🖗 No
M	cian; sertific ector,	Be	25. Was case referred to medical examiner? Hospital:		26. Place Other:	e of Death (Check	(only one)			
>	Phys this c	<u>유</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury a			ence 6 Other		
0	rding th. : After e fune	cate	1 P Natural 5 Pending (Month, Day, Ye 2 Accident Investigation		work?	es 2 🗆 No	zod. Describe no	w injury occurred		
DIVISION OF	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, stre	et, factory, office			reet and Number	or Rural I	Route Number,
2	tal or rs afte al Dir		building, etc. (S)	Decity)			City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. Or the Funeral Director: Affect his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exam	ination and/or invest	igation, in my opinion,	death occurred at	the time, date an	d place, and due t	to the caus	se(s) and manner stated.
	ithin 2 or the l	ğ	only one) 3 Certifying Nurse Practitioner: To the be 29b. Signature and title of certifier	st of my knowledge,	death occurred at the			e cause(s) and ma		
	F ≥ F ŏ		M	D	D69:				5	2012
	U		30. Name and address of person who completed cause of death	ı (Item 23a) (Type, P	rint)				A	
			JEEVAN ERRABOW 503	BYRN	STREET	CAMBR	IDCE	MARYL	MAD.	21012
	Stat Registra		31. Date filed (Month, Day, Year) 32 flegistrar's S	Signatur .	al					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physicia Medi Exami

Funeral

1 - For State Registrar

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

n/ al	Louella Reba Ruark				November	^{Day} 20)12 3:50 p M
er	4a. Facility Name (if not institution, give street and number) Chesapeake Woods Center			Location of Death		4c. County	of Death Orchester
		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
	218-30-1772 1 □ M 2 🖫 F	79 Yrs.	Months Days	Hours Min.	Oct. 17,	1933	Maryland
7	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
ecto	MD Dorchester	•	Но	opersvill	.e		1 ☐ Yes 2 🕱 No
	10e. Street and Number		10f. Zip Code		10g	g. Citizen of W	Vhat Country?
Funeral Director	1616 Steamboat Wharf Road			1634		US	
y Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ev Armed Forces? 1 □ Yes 2 12 N		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
Completed by	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o	ation during most of work	ding 16	b. Kind of Bu	usiness Industry
Sol	Elementary/Seconday (0-12) College (1-4 or 5+)	onoruse retired) crab picke	er		se	eafood
Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Mai	den Surname,)
မ	James Adams			Modia	Reynolds	3	
	19a. Informant's Name/Relationship (Type, Print) Melody D. Ruark daugl	19b. Maili 120597			al Route Number, Cit		tate, Zip Code) 19958
	20a. Method of Disposition	20h Place of Dispo	osition (Name of	1			City or Town, State
	1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Dorcheste	matory or other place er Mem. Pa	ark 11/	/9/12 C	ambrid	lge, MD
	21. Signature of Funeral Service Licensee	22			omas Fune		
=	D-I-R	ha daeth Daest ant			Cambridge,		
	23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ne death. Do not ent			or respiratory arrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death) a. Due to (or as a	Consequence of):	LAN	Cer			years !
٠	Sequentially list conditions, b.						/
nine	if any, leading to immediate Due to (or as a cause. Enter Underlying	consequence of):					
Ехаг	Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a	consequence of):	·				
Be Completed by Physician/Medical Examiner	d						
Mec	IF FEMALE:						
cian/	23b. Was decedent pregnant in the past 12 months? 1	pregnancy Fetal death 3 [ime of death 5 [Ectopic pregnand Other (specify)			23d. Date Mor	e of delivery nth Day Year
hysi	1 Yes 2 Ald 4 Pregnant at 1 9 Unknown 9 Unknown	into or dodair o E					
by P	Part II. Other significant conditions contributing to death but	not resulting in the u	ınderlying cause giv	en in Part I.			ibute to the cause of death?
sted					1 🗆 Yes		3 ☐ Probably 4 Dunknown
mpk					24a. Was an autopsy performe	р	Vere autopsy findings available rior to completion of cause of leath?
ပ္ပို	25. Was case referred to medical		26 Pla	ace of Death (Chec	1 □ Yes 2		Yes 2 Va
To B	examiner? Hospital:	t 2 ER/Outpatie	Othe	er: LA	ome 5 Residenc	e 6 🗆 Othe	r (Specify)
ate:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day,	Year) 28b. Time of injury	work	?	28d. Describe how i	njury occurre	d
tific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 290 Place of Injury	- At home, farm, str		Yes 2 No	20f Location (Street	t and Numba	r or Rural Route Number,
Cer	4 ☐ Homicide determined building, etc.		eet, lactory, onlee		City or Town, S		y or naral noute valition,
Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 3 Certifying Nurse Practioner: To the bright one of the bright one of the bright of the bright one of	mination and/or inves	tigation, in my opinic	n, death occurred a	t the time, date and p	lace, and due	to the cause(s) and manner stated.
2	29b. Signature and title of certifier		29c. License	number	29d	. Date signed	(Month, Day, Year)
	Jour Call Jan		HDO	044615		11/7	1/12
	30. Name and address of person who completed cause of dea	th (Item 23a) (Type, F	emble 5	treet (ambrida	ge M.	D21613
е	31. Date filed (Month, Day, Year) 31. Registrar	s Signature	Ne les			1	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Margaret Pearl Vovember 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Examiner Boonsboro Fahrney-Keedy Home & Village 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 217-16-2820 Director 1 🗆 M 2 🛛 F 91 Sept 5, 1921 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Washington 1 Yes 2 No Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26 Mountain View Drive U.S.A. 21713 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I t. Page 1 and 2 should be fill tment of Health and Mental tant; If item 27 is marked o ည Shifler Pearl Jones Shifler Ear1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Blue Ridge Drive Boonsboro, MD 21713 Helen Cianelli / sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If is
any injury or c 1 X Burial 2 Cremation 3 Removal from State Boonsboro, MD Boonsboro Cemetery 11/15/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike Boonsboro, MD 21713 Part 1 Inter the disease, or complications that cause shock, or heart failure. List only one cause of each ne. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) ears. Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as contequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director. I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 06-2011

State

JW-2

29b. Signature a

31. Date filed (Monti

Margaret

20311

cause of death (Item 23a) (Type, Print)

License number

29d. Date signed (Month, Day, Year)

NINEUMAN 12, IN 12

me M. Bornson M.D. 21715

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pı							_egible.	
		For State		State of N	/larylan		partment of		Mental Hyg	giene	0012	38762
		Registrar 1. Decedent's Name	e (First Middle	acti		Ce	ertificate of	Death	2. Date of Dea	Reg. No.	- 0 1 4	30702
Physicia		Venne	oth R	av Rosh					Month No v emba	Day	Year 20/2	3. Time of Death 5:30 A M
Medic Examin		4a. Facility Name (if		ive treet and number,	Jome	7	4b. City, Town, o	or Location of Death			ounty of Deatl	7 11
Funeral		5. Social Security N		Sex 7. A	ge (In yrs. Ia		If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1,		hplace (State or Foreign
Director		216 22 3 Usual Residence of	5996 Decedent	1 X M 2 □ F	85	Yrs.	Months Days	Hours Min.	Januare Januare	/ 17, 19	27	MARYIANI
aryland a-f shov fied at	ector	10a. State	10b. County	erset		Sals	ocation Sbury					10d. Inside City Limits 1 ☐ Yes 2 📈 No
death with the Maryland items 23a or 28a-f show ner must be notified at	Funeral Director	10e. Street and Nur	mber	E Road		3000	10f. Zip Code	15558		10g. Citize	n of What Co	
<u>a</u> <u>e</u>	by	11. Marital Status	-	If Vac Civa	? □ No		. Was Decedent of H If Yes, specify Cub		pecify Yes or No- Dican, etc.)		. Race - Amer Black, White	
nours a	etec	3 Widowed	4 ☐ Divorced 15. Decedent's	Year or Dates.	1945-19		edent's Usual Occu				of Business I	nduetry
ould be filed within 72 hours after of Mental Hygiene. marked other than "natural", or matic event, the Medical Exami	Completed	(Spe	ecify only highest	grade completed) College (1-4 or	r 5+)	(Giv	e kind of work done DO NOT use retired	during most of wor	king	1	nstru	, *
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id be f Menta arked atic ev	잍		Thor	nas Res	h			. (PORA.	Sch	ROVER	2
ar is		19a. Informant's Na				19b. Mai	ling Address (Street		ral Route Number	City or To	wn, State, Zip	Code)
and 2 s Health tem 27		Joan R 20a. Method of Disp		WIFE	20b. P	ace of Disc	Sauac position (Name of	GE Road	Salish		ation - City or	Town State
Page nent c ant: If			Cremation 3 5 Control Other (Spe	☐ Removal from Statecify)	te 1 C	emetery, cri IN+RVS	ematory or other pla	. : /////////	mber 2012	١.	sville	PA
permit. Pa Departmer Important any injury once.		21. Signature of Fu	neral Service Lic	A on h CC	0294		22. Name and Addre		ral Home		North	
		23a. Part 1. Enter t	the disease, or co	omplications that cause one cause on each li	ed the death	. Do not er	ter the mode of dyi	ng, such as cardiac	or respiratory arre		- K-3(,CE) C	Approximate Interval Between
Physician/		Immediate Cause (disease or conditio	(Final	a R	PSDE	rat	ory 1	ailu	ve			Onset and Death
Medical Examiner		resulting in death)		Due to (or a	s a consequ	ence of):	222	1/0	_			
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executed an and rial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	iinjury s	c. Due to (or a	s a consequ	ence of):						
E - E	a			d								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	at time of d	death 3	☐ Ectopic pregnan	су		236	d. Date of deli	ivery Day Year
hat the ed by t detach	by Phy	9 Unknown Part II. Other signif		contributing to death	but not resu	ulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
quires t en sign	q pa	A	ortic	ster	1086	0	1		1 □ Y	'es 2 🔽	No 3 🗆 Pr	obably 4 🗆 Unknown
he law re ite has be iage 2 sho	Completed		Flrid	rl fra	2 Y (llá	lion '		24a. Was a autop perfor	sy	prior to death?	opsy findings available completion of cause of
sian: T ertifica ctor, p	Be C	25. Was case referre	ed to medical					lace of Death (Chec		Z Equi NO	1 103	2 45110
Physic this or	ပ	1 Yes 25	A No	Hospital: 1 Inpa		ER/Outpati	ent 3 DOA Oth	4 Nursing H	ome 5 Resid			fy)
ending sath. or: After he funer	Certificate:	1 Natural 2 Accident	5 Pending Investigat	(Month, D		injury	wor		28d. Describe ho	ow injury o	ccurred	
al or Att		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place of Ir	njury - At hor etc. (Specify)		treet, factory, office		28f. Location (Si City or Town		lumber or Rur	al Route Number,
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page.	Medical	(Check 2	Medical Example 1	hysician: To the best of miner: On the basis of urse Practioner: To th	examination	and/or inve	stigation, in my opini	on, death occurred a	at the time, date ar	nd place, ar	nd due to the c	ause(s) and manner stated.
2 A with a contract of the con		29b. Signature and	title of certifier	ecen'	M	0	29c. Licens	10661	50	29d. Date s	signed (Month	, Day, Year)
nes		30. Name and addre	ess of person wh	o completed cause of	death (Item	23a) (Type,	Print)	Cita	T64 C.		A.	1 110.
Stat		31. Date filed Moot	V 1 5 201	2 32. Regist	trar's Signat	ire foar	Med Med	SUUL S	04 CIV	MULE	MIGNE	7 1011
Registra	ir		29	- Maria	1	11						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year PM :05 2012 Novembe Medical Kenneth Howard Robertson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany ions Center Cumberland If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours **Director** 214-05-8957 1**X** M 2 □ F 93 24,1918 MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes X No Allegany Cumberland MD Ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 901 Seton Drive 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cumberland Steel Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic evea once. Howard Dallas Robertson Vesta May (Nee) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 West Braddock Rd. LaVale, 21502 Nicole Logsdon granddaugh MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Mary's Cem 11/15/12 Qonation 5 Other (Specify) Cumberland, Md 22. Name and Address of Facility Scarpelli Funeral Home, of Funeral Service Licensee Si natur 108 Virginia Cumberland MD Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part shoc Approximate Interval Between Cause (Final Onset and Death Ph_sician/ Due to (or as a consequence of): Ementh disease or unditi-resulting in death) ndition Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Let or Underlying Cause (Disease or injury that initiated events seculting in death). Let Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) Hospital 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0055335 Nov 13, 20/2

State Registrar

nds

Bishop Walsh Road Cumberlano

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Same	1	- 1	T-marr	0	-		-	

	1- For State Registrar		Certifica	te of D	eath		R	eg. No.	
Physician/	Decedent's Name (First, Middle)	e,Last)				·	Date of Dea Month	Day Year	3. Time of Death
Medical Examiner	Allollolly		omano	1.0			Novembe	r 10, 2012	1017 hrs
)	4a. Facility Name (if not institution Western Maryland Re	gional Medical Cente		C	City, Town, or Lo Cumberland	ocation of L	Jeath	4c. County of Allegany	Death
Funeral	5. Social Security Number 025-42-2074		(In yrs. last birth		f Under 1 Year Months Days	If Under 2 Hours	Min	· 1	Birthplace (State or Foreign
Director		1XM 2F 5	5	Yrs.	July Days	, iouis	03/29/	1957	Country) Massachusetts
, and	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	MD All	.egany	Cumb	erla	nd				1 Y Yes 2 No
Maryland 28a-f show d at once. rector	10e. Street and Number	, , , , , , , , , , , , , , , , , , ,			Of. Zip Code		1	0g. Citizen of Wha	t Country?
death with the Maryland or items 23s or 28s-f sho must he notified at once-uneral Director	640 Shriv				215			USA	
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent I arried Armed Forces?					? (Specify Yes or No uerto Rican, etc.)	14. Race - White,	American Indian, Black, etc.
r nu	3 V Widowed 4 Div	orced If Yes, Give Year	X No	1 Ye	s 21 No	specify:		Specify:	White
tural sanio	15. Decedent's Education (Spe	or Dates:	pleted) 16a. D	ecedent's	Jsual Occupatio	n (Give kin		16b. Kind of Busi	
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12)	College (1-4 or 5	+) d	_	of working life. [OO NOT us	e retired)		
5-003(iled within Hygiene. d other that the Media	12			Mu	sician				ainment
	17. Father's Name (First, Middle, Daniel	Joseph	Romano		18	3.Mothers Hele	Name (First, Middle, PN	Maiden Surname) May	Pilioglos
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental batt: If item 27 is marked or other traumatic event, To Be	19a. Informant's Name/Relations Daniel J. Rom			-			er or Rural Route Nur		
E c d d a s	20a. Method of Disposition				n (Name of ceme		rcle, Orl		32824 City or Town, State
Baltimore, Permit. Pages I ar Pepartment of Hee Important: If itee	1 Burial 2 X Cremation	n 3 Removal from Sta	te cremato	ry or other	place)				
	4 Donation 5 Other State 21. Signature of Funeral Bervice		Cumber		Cremato		1/12/2012		rland, MD
Balt permit. Depart Impor	21 gladue of Pulleral Belvice	i do		404	Decatu	n Str	eet, Cumb	ily rune: erland N	ral Home, P.A. MD 21502
Physician	23a. Part Enter the disease, or		the death. Do not						t Approximate Interval
/Modical	failure. List only one cause Immediate Cause (Final disease	0.1.1.1	oma						Between Onset and Death
xaminer	or condition resulting in death)	Due to (or as a conse							
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						
led nasit	events resulting in death) Last	Due to (or as a conse	quence of):						
760, crate be executed physician and the burial - transit //Medical Examiner	UNPENDED	AMENDED 28e,	per me,	3934	12-17-12	2 sm			
Box 68760, death certificate be attending physic of for use as the burnysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom		Fetal	death 3	Ectopic p	regnancy	23d. Date of d Month	elivery Day Year
). Box 68 t the death certif by the attending sched for use as Physician	past 12 months?	4 Pregnant at t	time of death 5	=	(Specify)				2.,
be dea / the a hed fo	Fest 2 No 9 On	9 Unknown					200 Didd	- h	ute to the cause of death?
of Vital Records, P.O. Box 687 ng Physician: The law requires that the death certific. The law requires that the attending ther this certificate has been signed by the attending menal director, page 2 should be detached for use as 1 no Be Completed by Physician!		gons contributing to death	but not resulting	in the und	erlying cause giv	en in Part			Probably 4 Unknown
Records, F : The law requires ficate has been sign ; page 2 should be c							24a. Was		ere autopsy findings available
COF s law r e 2 sh e 2 sh			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					rmed? de	or to completion of cause of ath?
ii The tiffcat or, page	25. Was case referred to medica	al			26 Place o	of Death (C	heck only one)	2 ✓ No 1	Yes 2 No
Vital Rec ysician: The lhis certificate director, page	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatient 3		ther -	Nursing Home 5	Residence 6	Other:
ding Ph. After the funeral	27. Manner of Death	28a. Date of Injui	ry 28b. T	ime of Inju	ry 28c. Injury	at Work?		how injury оссите	d
ion trendi leath. tor: /	1 Natural 5 Pend 2 Accident Inve	ding FOUND: Nov 5, 2012	1855 FOUI		1 Ye	es 2 🗸 N	Subject fell		
Division o spiral or Attending tours after death. Beral Director: Aftilled in by the function:	3 Suicide 6 Cou		ury - At home, far Home	m, street, f	actory, office bu	ilding, etc.	or Town,		or Rural Route Number, City
8 5	29a. Certifier (Check only 1 Certifying P	hysician: To the best of my	knowledge, deal				e, and due to the cau	se(s) and manner a	as stated.
To the Hos within 24 h To the Fur completely		miner: On the basis of exam and manner stated.	nination and/or in	vestigation			rred at the time, date		
∑∑	29b. Signature and title of certific	er			29c. License O.C.M			29d. Date signed November 1	1 (Month, Day, Year)
	ard 1	Tulla	noth (Hor- 02-)	_	J	·. .		140 volitiber 1	1, 2012
ox of the ost	30. Name and address of persor Carol H. Allan, MD	Assistant Medical Ex	, ,) W. Ba	timore Stree	et, Baltim	nore, MD 21223		, _
State Registra	11011	32. Registrar	's Signature	home	V. J				
DHMH 17 Rev 1/2001		OCME	ORI	GINAL			··· · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 38765 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ificate of Death		Reg.	No.	
Physici ledical Exam		1. Decedent's Name (First, Middle,Last		-5		Date of Death Month D October 17,	year 2012	3. Time of Death 0100 hrs
)		4a. Facility Name (if not institution, give 1515 Philadelphia Road	street and number)	4b. City, Town, o	or Location of Death	1	4c. County of Death Harford	h
Funeral Director		5. Social Security Number 6. Sec.	7. Age (In yrs. las	st birthday) If Under 1 Ye Months Da		— ''	MM/DD/YYYY) 9. Bir Foreig Co	
nd show any	7.	10a. State 10b. County		Town or Location				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zip Code	85	10g.	Citizen of What Cou	
er death with , or items 2:	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Yes, specify Cuba	in, Mexican, Puerto		White, etc.	ican Indian, Black,
more, MD 21215-0036 Pages and 2 should be filed within 72 hours after death with the Maryland tent of He and Mental Hygiewith 172 hours after death with the Maryland witt if item 27 is marked other than "natural", or items 23a or 28a-f she wither traumatic event, the Medical Examiner must be notified at once	ompleted by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	or Dates:	1 Yes 2 No. 16a. Decedent's Usual Occupa during most of working life	ation (Give kind of v	vork done 16	Specify: (a)	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	Ü	UNK. 17. Father's Name (First Middle, Last)	UNK.	ASSEMB	18. Mother's Name	(First, Middle, Maid		-
D 21215-00; should be filed within and Mental Hygiene. 7 is marked other til natic event, the Med	To Be	19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Stre	VERC. et and Number or F	Rural Route Number	r, City or Town, State	e, Zip Code)
re, MD 2 s 1 and 2 shou of Health and N If item 27 is n	:	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State cre	ace of Disposition (Name of ce ematory or other place)	emetery,	ABERDEE. Date 20	Oc. Location - City or	Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		4 Donation 5 Other Specify: 21. Signafure of Funeral Service Licens		22. Name and Addres	s of Facility Sk	28 12 2200 Fu	GLEN BUT	EN E, MD
m ឱ្ង∄់ធ្វ Physician	4	23a. Part I. Enter the disease, or compli	cations that caused the death. [2829 Hung	such as cardiac o	Bactimose respiratory arrest,	€, mis 21 shock, or heart	224 Approximate Interval
/Medical Examiner			th line. Pneumonia Due to (or as a consequence of):					Between Onset and Death
- 1	-	Sequentially list conditions, b	ue to (or as a consequence of):					
_ ;	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of):					
760, icate be executed physician and the burial - transit	Medical E	d. X UNPENDED	AMENDED 23a, pt.II	,27,per me,g9	39 5-9-13	sm		
that the death certificate be need by the attending physic deached for use as the bur	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. if yes, outcome of pregnal 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3	Ectopic pregna		23d. Date of delivery Month	Zay Year
P.O. Eres that the d		Part II. Other significant conditions Osteopenia, Osteo	contributing to death but not resu				cco use contribute to	the cause of death?
cords law requi has been	Completed by	bone metastasis I				24a. Was an autopsy performed	prior to c d? death?	topsy findings available completion of cause of
Vital Rec hysician: The this certificate I director, page	Bec	25. Was case referred to medical		26.Place	e of Death (Check o	only one)		
n of Vita ding Physicia After this ce funeral direct	2	1 Yes 2 No		R/Outpatient 3 DOA		g Home 5 Res	sidence 6 🗸 Other	Scene
F = 7 4 1		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)	1	ry at Work? Yes 2 No	28d. Describe how		
Division ospital or Attenchours after death ineral Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom (Specify)	ne, farm, street, factory, office b	ouilding, etc.	28f. Location (Stree or Town, State		ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ and manner stated	Vor investigation, in my opinion	n, death occurred at			
	≊	29b. Signature and title of certifier		29c, Licens O.C.			od. Date signed (Mon October 20, 2012	
		30. Name and address of person who co Donna M. Vincenti, MD		,	Street, Baltim	ore, MD 21223	3	
St Regist	ate rar	31. Date filed (MNOV 3° 0 201						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:10 P.M nwoo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne Stevensville Grove 200 Terrapin If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F (Month Months Hours Min Director or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Stevensville Queen 10e. Street and Number 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a USA 21666 200 Terrapin 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) erman hart Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Muble Stevensville, MD 200 lerra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/10/2012 Grasony ille 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of acility 21. Signature of Funeral Service Licenses Henry Funeral Hon any MD.21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ₽hysician/ MyElon Miltiple Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or; To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 25. Was case referred to medical by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🛣 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director.,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 2540

Registrar's Signatur

Conneville ROAD

and address of person who completed cause of death (Item 23a) (Type, Print)

UKENY

NOV 08

31. Date filed (Month

2012

Centreville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1757 **JAMES** LAWSON STERLING 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO SAU 56VR4 TENINSULA If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 216-56-1117 1 🔯 M 2 🗆 F 60 April 7, 1952 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Worcester Eden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21822 USA 7266 Meadow Bridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No 1972—
If Yes, Give
Year or Dates. 1978 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Carpentry 12 <u>Carpenter</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Philip Sterling Stella Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7266 Meadow Bridge Road - Eden, MD 21822 Wanda Sterling (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If It
any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Page 1 Zion Church Cemetery 11/8/2012 Eden, Maryland 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. Signature of Funeral Service Licensee Beth Bradshaw-Pruitt 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con a uence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 X No 1 Inpatient 2X ER/Outpatient 3 I DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical administration of the basis of examination allow investigation, it is upon the form of the basis of examination of exa 29b. Signature and title of certifie 29c. License number 153776

CAI

State Registrar 31. Date filed (Month, Day, Year) NOV 0 7

19149

CRNP 100 E CAYIUII

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLIFFOLD

5ALISBYLY MO 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 per FH G934 12/5/12 dk
State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 1, 2012 19:25 Physician/ William Jerome Sterling III Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Wicomico Salisbury 216 Creekside Drive Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Funeral Months Days Hours 1 🖾 M 2 🗆 F Director 219-36-7431 12 23 1940 Yrs New York 71 Usual Residence of Deced 10d. Inside City Limits if Haatth and Mantal Hyglane. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Macilcal Examination rotation of 10b. County 10c. City, Town or Location 10a. State fliad within 72 hours after daath with tha Maryland Director 1 Yes 2X No Salisbury Maryland | Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral USA 21804 216 Creekside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 K Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Publishing Publisher 4 12 18. Mother's Name (First, Middle, Maiden Surname) Be parmit. Paga 1 and 2 should ba fliad Dapartment of Haath and Mantal Hy Important: if item 27 is marked oth any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) Josephine Planz မှ Robert W. Sterling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 Creekside Dr., Salisbury, Maryland 21804 Pat Sterling wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11 06 2012 Salisbury, Maryland 4 Donation 5 Other (Specify) Salisbury Crematory 22. Name and Address of Facility of Funeral Service 181 loway Funeral Home P.A. Salisbury, Maryland 21804 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas se, or complications that cau hock, or heart failure. List only one cause mediate Cause (Final WANI Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner aftar death.

Director: Aftar this cartificata has been signed by the attending physician and his but the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Recolds, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant Day in the past 12 months?

1 Yes 2 No

9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical a examiner? Other: Hospital 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 욛 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 1 Natural 5 Pending М Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 É 31. Date filed (Month) Registrar's Signa State Registrar HB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hvoiene Certificate of Death Registrar 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2019 12:30 P Physician/ Frances Jeannette Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 600A Taney Avenue Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Apr. 7, Davs Months Hours 217-18-7579 Mary land Director 88 Usual Residence of Decedent ar than "natural", or Iteme 23a or 28a-f show the Modical Examiner must be notified at 10c. City, Town or Location Frederick 10a. State 10b. County 10d, Inside City Limits 72 hours efter death with the Maryland Director MD Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600A Taney Avenue 21702 United States Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black White etc. ٥ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filad within 77 Department of Health end Marital Hyglene. Important: If Item 27 is marked othar than any Injury or other traumatic event, Ite M. Elementary/Secondary (0-12) College (1-4 or 5+) Consumer Credit Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Rhodes Adams Sr. Anna Irene Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Willard (Daughter) 400 Dovetail Circle, Summerville, SC 29483 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Mt. Olivet Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/9/2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licenses Reeney & Bastord P.A. Funeral Home 106 E. Church Street, Frederick, Maryland 21701 MO1612 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ and lomy op a thu disease or condition resulting in death) Medical Due to (or as a consuluence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attanding Phyelcian: The law requires thet the death certificate be axecuted attending physicien and I for use as the burlal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ad by the a g 🔲 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificete hes been signad I funeral director, pege 2 should be dei 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\stackrel{\leftarrow}{K}$ Residence 6 \square Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To tha within 2

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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FACC

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Stafforc 10:54 M 2012 tenr /Medical 4a. Facility Name (I not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartord Harford Havre de Grace Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Aug. | Aug. | 13 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**⊠** M 2□ F Alabama 267-76-5737 1947 65 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State show ral", or items 23a or 28a-f shov Examinar must be notified at 1 XYes 2 □ No Director MD Cecil Perry Point 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21902 U.S.A. 515 Broad St. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 197 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1971 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Yes Give Specify: -19753 ☐ Widowed 4 X Divorced Ye ar or Dates: "natural", 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than traumatic event, If a Me Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Food Preparation Cook 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas Langille Etta Mae Mixon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any injury or other trau
once. Sheree A. Green (sister) 968 Blackbird Greenspring Rd. Smyrna, DE. 19977 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Del Vet Memorial Cem. 11/13/12 Bear, DE. 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Liebses ²² Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or it art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cereboniascular accident /Medical Due to (or as a consequence of): Examiner amal h wo like Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of) 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) Ö 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed Physician: The certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending 1 ☑ Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MI 2012 2006-1015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Have de Cru MD21078 501 31. Date filed (Month, Day, Yea 32. Registra State

Registrar

Amend item #5 per FH CCHD 11/09/2032 at of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:48 AM Junella Diane Spencer 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 210 Shipley Avenue Westminster Carroll 5. Social Se**2115/1841**28796 -215-64-9796 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Davs (Month, Day, Year) 59 1 □ M 2 🔏 F **Director** 12/19/1952 MD Usual Residence of Decedent 28a-f show I Hygiene. other than "natural", or items 23a or 25e-1 5.1.2. 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 210 Shipley Avenue 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify White 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Program Specialist - Exec. Assist. Human Services should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl Lee Mathis Anna Marie Rahnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 210 Shipley Avenue, Westminster, MD James Spencer/son 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Holly Hills Mem. Gard. 11/09/12 | Essex, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Farmitts Funeral Home and Chapel, PA 126-412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cape on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events physician are to the burial-t Due to (or as a consequence of) resulting in death) Last Physician/Medical ass IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has autopsy performed this certificate 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Investigation M Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 2. To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title Name and address of person who completed cause of death (Item 23a) (Type, Print) ersun MO ev ber 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STEPHENS DOROTHY ELIZABETH 2012 4:50 A Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours Director 213-18-4948 1 🗆 M 2 🗶 F 91 PITTSVILLE, MD DEC 16, 1920 10b. County death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director SUSSEX COUNTY FRANKFORD DELAWARE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 LOWE'S CROSSING ROAD 19945 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 Yes 2 X No Specify. Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER/OPERATOR **GRAIN FARM** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ည CHARLIE CARRIE SHORT LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **BRUCE STEPHENS** (SON) 21057 LOWE'S CROSSING RD., FRANKFORD, DE 19945 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) JONES CEMETERY NOV 05,2012 GUMBORO, DE 19945 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) #Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): eral Director. After this certificate has been signed by the attending physician and filled in by the tuneral director, page 2 should be detached for use as the burial-transi Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 1 N6 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 N/No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) DH6

Registrar
DHMH 17 Rev 06-2011

State

OPPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 2012 Susanna Shanto Nov. 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1105 Eastbourne Place Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 202 12 4808 Director 1 M 2 XF 93 PA 01/06/1919 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1105 EastbournePlace 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. á 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 🗋 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Federal Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Church Street Rockville, MD 20850 Douglas R.Coggins/Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/8/2012 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses SUSCOCTONIC 22. Name and Address of Facility Briscoe-Tonic Funeral Home Kimerley 2294 Old Washington Rd.Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACUTE MYOCARDIAL Medical Due to (or as a consequence of) Examiner DEMENTA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year cate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ASSISTED Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1 ☐ Yes 2 W No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Tes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific **Division of Vital**

State

completely

Medical

29a Certifier

29b. Signature and title of certifier

31. Date filed (Mort)

5. M. NAYAR MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3717

32 Registrar's Signatur

Registrar DHMH 17 Rev 06-2011 38 IK

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D-17874

BRENTWOOD, MD 20722

29d. Date signed (Month, Day, Year)

11-3-2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ NOV. 6 Bay James William Smith 2012 3:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Waldorf 3804 Brewster Circle Charles Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days (Month, Day, Year) 2/29/1935 Hours 76 223 40 3192 **Director** show 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director must be notified 28a-f Charles Waldorf 1 X Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a Funeral USA 3804 Brewster Circle 20601 "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify Specify:Black Completed 3 Widowed 4 Divorced Year or Dates. 1953 – 56 Health and Mental Hygiene. tem 27 is marked other than "natur ither traumatic event, the Medical I Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Courier 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Jackson Clyde Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Harris/ Daughter 3804 Brewster Cir. Waldorf, MD 20601 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 11/5/2012 Cheltenham, MD 4 Donation 5 Other (Specify) MD Veterans Cem. 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 21. Signature of Funeral Service License WICL 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner TWYE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and s the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a donsequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 use as attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 06 ause of death (Item 23a) (Type who completed 2060?

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Margaret Ann Swisher 12:50 aM 101ember 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 215-34-3464 **Director** 77 1 □ M 2 🗶 F June 14, 1935 Maryland Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 333 Mill Street 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ Factory Worker Automobile Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Stote1mver Phebe Miller Stote1mver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Stotelmyer / nephew 21348 Ruble Road Boonsboro, MD21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State Stauffer Crematory 11/13/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral ce Lice 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike Boonsboro, MD 21713 Enter the disease, or complic, or heart failure. List only one s that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e on ach line. Approximate te Cause (Final Onset and Death m etastat Physician. MISCASE disea or condition resulting in death) Medical ue to (or as a consequence of): **Examiner** Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): at To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. To the Funeral Director; After this certificate has autopsy performed death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAR'S MUNSIMED

istrar's Signature

29c. License number 2060396

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ November 9, 2012 Virginia Kaye Shirley 9:00 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12930 Pecktonville Road Big Pool Washington . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Days Hours Min. 219-66-1374 Director 1 - M 2 1 F 57 Nov. 2, 1955 Florida Usual Residence of Decedent 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Maryland Washington Big Pool 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12930 Pecktonville Road 21711 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ğ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Deli/Bakery Worker Grocery Store of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Daniel Noble Joann (NMN) Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12930 Pecktonville Rd. Big Pool, MD 21711 David M. Shirley Jr. (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Greenlawn Mem. Park Nov. 14,2012 Williamsport, Maryland ture of Puneral Service License 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition reducto resulting in death) Medical Examiner 30 418 with Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed 115 ancer that initiated events resulting in death) Last Physician/Medical 755 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number massono 111912012 D14800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 240 Brederick St. Hugers Town MD 21740 MASSOUD B. ALIZADEH, UD

State

Registrar

31. Date filed (Month.

Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amed Item 4 per FFH 11/16/12 JW/WCHD Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 9,2012 Kent E. Shoemaker November 2:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 45 Wakefield Road Hagerstown Washington 5. Social Sec 7 dy 10 10 170 173 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 218-74-9713 Director 1 X M 2 🗆 F 56 Oct. 14, 1956 Ohio or 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Washington 1 AYes 2 □ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 45 Wakefield Road 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction 0 Heavy Equiptment Operator Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Shoemaker Phyllis J. Nickell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other ti Phyllis J. Shoemaker 16716 Taylors Landing Road Sharpsburg, MD 21782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Nov.11,2012 Hagerstown, Maryland 21. Signature of Funeral Service Licensee any In 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MyocardiA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LARS DIONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Melitus Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown typucholesterolemiA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License number 30. Name and address of person ause of death (Item 23a) (Type, Print) Steven 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar NEWSCALE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Marylan					Mental H	ygiene)			
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Toutfer, Dorothy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Registrar 1. Decedent's Name (First, Middle	l ast)		Cer	tificate	OIL			2. Date of De	Reg. No.	2012	3. Time o	Death
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/Medica		4a. Facility Name (If not institution	, give street and num	ber)		4b. City,	Town, or	Location o	of Death			County of Dea		
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Funeral		5. Social Security Number 218-60-1300	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. le	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da 01/03/	rth ay, Year) 1 Q / Q	I Co	nthplace (State of ou <i>ntry)</i> St Virg	_
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensele	100)	22	2. Name ar	d Addres	s of Facili	ty Upc	hurch Cumbe	Funer rland	al Hom	e. P.A. 21502	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical (ng Physician: To the Examiner: On the b											(s)
To the within To the compl	Me	29b. Signature and title of certifie	· (VA	11		290		number	01	2	29d. Dat	e signed (Mor	nth, Day, Year)	
4-			MM	M			DO	06	188		Nove	uper	13,20	12
nes		30. Name and address of person	who completed cau	LA LUN				49	940 E	astern A	venue	, Baltim	ore, MD,	21224
Sta Registra		31. Date filed (Month, Day, Year)	012 /32. R	egistrar's Signal	ture	that								
1MH 17 Rev 1/20	-77	1101 = -	13000	7	12									

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Terry Lee Sprouse Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 578 64 3780 Director 1 → M 2 □ F Maryland Yrs April 4, 1948 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4226 Columbia Park Road 20604 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No 1968—
If Ass, Give Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Widowed 4 Divorced 1973 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) State Department Construction 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 Is marked ot Celia Victoria Smith Robert Edward Sprouse, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Sprouse (brother) 11513 Timberbrook Drive, Waldorf, MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 5, 2012 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses m01555 Ferry Road, Clinton, MD 20735 23a. 1 - 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Month Intracerebral Hemorrhage Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed 1 Year Thrombocytopenia use as the burial-trar Due to (or as a consequence of): resulting in death) Last eate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Cirrhosis of Liver Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XX Unknown Sepsis Acute renal Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform After this certificate I Yes 2 XXN 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ER/Outpatient 3 DOA မူ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 XXNatural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Francis Freisinger, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

D70427

November

2012

trancis treisinger MJ

NOV 0 5 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
6, PER VERBAL G933 11/30/12 TRT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 11 12Day 2012 7:15p M Vitto Sgaggero /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** 20302 Helena Drive SE Oldtown 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F 89 02-04-1923 Maryland **Director** 216-14-1016 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maltal Exeminat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Allegany Oldtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20302 Helena Drive SE 21555 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ If Yes. Give Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car Man Railraod 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Frank Sgaggero Lena Sgaggero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20302 Helena Drive SE Oldtown, MD 21550 Sue Sgaggero 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Michael's Cem. 11-16-2012 Frostburg, MD 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee HIGA mas117 60 W. Main Street Frostburg, MD 21532 Dowess 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal Physician tarluve disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Artery Disease Coronany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed COPD and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 24 hours after death.

Funeral Director: After this certificate has been signed by the atte etely filled in by the funeral director, page 2 should be detached for a Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 2 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 | Yes 2 | → 10 Certification: To 1 ☐ Inpatient · 2 ☐ Livoupa tient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Seton Dr Cumberland MD 21502 ANITA VAGNONI MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar amended item 20-te-wchd-11-1Gertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Arthur Timmons 5 11 2012 0150 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harrison Senior Living of SnH Snow Hill Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **J**M 2 □ F Director 215-26-4966 6-25-1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Me & al Examiner must be notified 1 ☐ Yes 2 ☑ No Funeral Director Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 Teaberry 21863 Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Speciallack Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Walter Sandusky Elementary/Secondary (0-12) College (1-4or 5+) Trucking Co 3 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minor Timmons Lillian Mumford ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Timmons/Son 26074 Hollyville Rd, Millsboro, DE 19966 20b. Place of Disposition (Name of St. Campatery, crampatary, or other place)
St. James Holliness Cem
Snow-Hill-Del-Cem11-17-2012 Snow Hill,
Bennie Smith
Funeral Home Salisbury, MD 21801 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it
any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heart Failuxe Congestine 1 secoth /Medical Due to (or as a consequence of): Examiner stage Sequentially list conditions, any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;

completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063253 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11-5-12

State Registrar 31. Date filed (Month, Day, Year)

Month, Day, Year)

32. Registrar's Signature

Snow Hill, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 3 Year TRAVERS Physician/ 12:32 PM LEON 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER DORCHESTER CENERAL HOSPITAL CAMBRIDGE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Funeral Country Mary Land 219-34-4122 72 May 4, 1940 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD Dorchester Cambridge 1 X Yes 2 No death with the Mai 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 701 Race Street, Apt. 300 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 🔀 No Specify: Specify. "natural", Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) foreman construction Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ၉ Adelle Meekins Bennie G. Travers. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Pleasant St., Cambridge, MD 21613 Laura Laird daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cambridge Cemetery 11/8/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses Wellin m. Verenica 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DISEASE KIDNEY END STA GE Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine FAILURE To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last CONGESTIVE g physician and s the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONARY DISEASE Division of Vital Records, OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown CHRONIC Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? nis certificate h I director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes _2 🕦 No 1 Thinpatient 2 ER/Outpatient 3 DOA ပ After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Dear 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural Accider injury 5 Pending thin 24 hours after death.

the Funeral Director: After ampleted filled in by the fun 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the control of the basis of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F
complet only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69234 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

503

BYIZH

NOV 98 2012

31. Date filed (Month, Day, Year)

STREET

CAMBRIDGE

2. Registrar's Sign

MARYLAND 21613.

JEEVAN ERRABOLU MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 John Emory Tippett II November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert 4107 Riverview Court Dunkirk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) Director 218-54-9427 1 🕅 M 2 □ F 11/16/1948 63 Marvland 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Calvert Huntingtown 10f. Zip Code 10e. Street and Numbe 10a. Citizen of What Country? Funeral USA 5671 Warren Drive 20639 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisory Environmental Profection Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thelma Martha Beall John Emory Tippett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is 1 6535 Dobbins Court, LaPlata, Angela L. Kabala, Daughter MD20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11-09-2012 | Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lung adendiavinoma disease or condition resulting in death) Medical consequence of): Examiner Sequentially flat conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 N Other (Specify) Daughter's 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 056024 2102 9 VOU KW

DHMH 17 Rev 06-2011

1

State

Registrar

110 Hospital Road

32. Registrar's Signature

Suite 110

trince Frederick MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth LALboth

31. Date filed (Month, Day, Year)

NOV - 8 2012

			1 = For State Registrar	State of M	laryland /		ment of H	ealth and N Death		giene	112	38786
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath	V	3. Time of Death
	Physici /Medic		Odessa	M. Tayl	Lor				Month Oct 2	Day 4. 2	Year 012	4.20 P M
	Examir		4a. Facility Name (If not institution			4		Location of Death		4c. Co	unty of Death	
			Bradford O	aks Center	£			nton		Pri	nce G	eorge's
	Funeral Director		5. Social Security Number 412-76-4737	6. Sex 7. A	ge (In yrs. last 64		f Under 1 Year flonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 9 / 11 / 1	v, Year)	9. Birth Cou T N	place (State or Foreign intry)
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c City To	own or Locat	ion					10d. Inside City Limits
	Maryla a-f sho	tor	MD Calv	ert			Freder	ick				1 ☐ Yes 2X☐ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 1625 Mint Co	urt			10f. Zip Code 2067	8		10g. Citizer US	n of What Cou A	intry?
36	s i and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other treumatic event, the Modical Examinations are retified at	by Funer	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Moivorced	12. Was Decedent Armed Forces' ied 1 Yes 2 1 If Yes, Give Year or Dates:	?	If Y	s Decedent of Hi es, specify Cuba Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	İ	Race - Ameri Black, White pecify: B1	, etc.
215-0036	72 hou	eted	15. Deceden (Specify only higher	t's Education st grade completed)	1	6a. Deceden (Give kin	t's Usual Occupa d of work done o	ition luring most of work)	king	16b. Kind	of Business/ir	ndustry
2121	d within giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		not use retired ptioni			Tele	commu	nications
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other treumatic event, In M. ODGe.	Be	17. Father's Name (First, Middle, Unk	Last) NOWN				18. Mother's Nam		Maiden Su unkn		
Z	should nd Men marka umatic	은	19a. Informant's Name/Relations	hip (Type, Print)	1	9b. Mailing A	Address (Street a	and Number or Ru				ip Code)
	and 2 ; ealth ar n 27 Is		Candice Kinne	dauahtar				t. Prin				
Je,	s 1 and Head item of the other		20a. Method of Disposition		0000	of Disposition	on (Name of ory or other place	g)	Date	20c. Local	tion - City or T	own, State
E	Pages nent of I int: if ite		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S		Ches	.High	lands	Cem.11/	8/2012	Por	t Rep	ublic, MD
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service	Licensee		22. N 1 4 5	ame and Addres	s of Facility Se E Beach	well F	uner	al Hor	ne, P.A. 1.,MD20678
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	d the death. D	o not enter t	he mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Cer	Inde	VA	suilar	Acci de	1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequen	ce of):						
	Lxammer	L	Sequentially list conditions,	b								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	CO OI):						
•	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as	s a consequenc	ce of):						
8760,	cate be executed oblysician and the burial-transit	aiE										
687	tificate ig phys as the	edicai		d								
.O. Box	ne death cer the attendir thed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3∐Ec	topic pregnancy ther (specify)			230	I. Date of deliving Month	very Day Year
<u>α</u>	ires that the signed by die detaction	by Ph	Part II. Other significant condition	ons contributing to death I	but not resultin	g in the unde	riying cause give	en in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
ıd	w require been sig should b								101	es 2 1	No 3□Pro	bably 4 Unknown
Records,	The law resate has be page 2 sho	Completed							24a. Was autop perfo 1 \(\text{Yes} \)		24b. Were aut prior to co death? 1 🔲 Yes	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Dea		-		
	ys dis	일	1 Yes 2 No	Hospital: 1 Inpati	ient 2 ER/	Outpatient	3□ DOA Othe	Nursing H	ome 5 Resid	dence 6	Other (Spec	ify)
ion of	ding After fune		27. Manner of Death 1 Matural 5 ☐ Pendin 2 ☐ Accident investig		ury 281 ay Year)	b. Time of Injury	28c. Injury Work M 1 🗀	at ?? Yes 2 □ No	28d. Describe h	now injury o	ccurred	
Division	in Dir	Certification;	3 Suicide 6 Could a determined	ined 288. Place of in	ijury · At home tc. <i>(Specify)</i>	, farm, street	, factory, office		28f. Location (S City or Tox		lumber or Rui	ral Route Number,
_	To the Hospitel or within 24 hours after To the Funeral Direction Completely filled in I	Medical Ce	(Check only 2 Medical	g Physician: To the best Examiner: On the basis of and manner s	of examination	and/or invest	tigation, in my or	inion, death occur	rred at the time.	date and pl	ace, and due	stated. to the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifie				29c. License	number		29d. Date s	igned (Month	, Day, Year)
	->		> Was	1 leinen			D35	206		0	crose	126,2012
19	3	1	30. Name and address of person	who completed cause of 32. Regist	death (Item 23	a) (Type, Prin	nt) necks Re	m/ C.L	WASHIY	Pm 1M	40	
	Sta	te	William (.) 31. Date filed (Month, Day, Year)	32. Regist	ra s Signature	001	7	Port		•		
	Registr		OC.	1312012 L	Znewa	1. 1	parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

A Facility Name of Frost institution, give street and number 1703 East West Hwy #415 Silver Spring de. Cause of Death Montgomery 1703 East West Hwy #415 Silver Spring Director 1703 East West Hwy #415 Silver Spring Director 1704 East West Hwy #415 Silver Spring Director 1705 East West Hwy #415 Silver Spring 1705 East West Hwy #415 Silver Spring 1705 East West Hwy #415 Silver Spring 1705 East West Hwy Apt 415 Silver Spring	37					
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Respiratory Failure Medical Examiner						
Medical Examiner Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)						
Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
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So year of the past 12 months? 1 Yes 2 No 3 Probably 4 Unk 1 Yes 2 No 3 Probably 4 Unk	- 12 (12)					
in the past 12 months? 1 Yes 2 No 9 Unknown Out of the past 12 months? A Pregnant at time of death 5 Other (specify)						
O the standard panel of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the part II. 1 Yes 2 X No 3 Probably 4 Unk						
So the series of	?					
Ö = = = 0	nown					
24a. Was an 24b. Were autopsy findings avail	able					
The part of the pa) OI					
The second of th						
Hospital: Hospital: DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 27. Matural 5 Pending (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred injury 28d. Describe how injury occurred						
27. Manner of Death 1						
The state of the s						
Hypothyroidism Complete Comp	stated					
Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.						
29b. Signature an little of certifier 29c. License number 29d. Date signed (Month, Day, Year)						
30. Name and address of person who completed cause of death (Item 23a) (Typa Print)						
CHRISTIAN NWANKUS JAMD, 7411 RUGS RD, HYATTSTIME IND 20883						
Talles la la la la la la la la la la la la la						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RUTH INEZ TRAVIS Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 02/11/1929 West Virginia 83 **Director** 215-26-6291 1 □ M 2 🗓 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits Director notified Fort Ashby 1 Yes 2 No WV Mineral 10e, Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral U.S.A. 26719 Dan's Run Road items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exar Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Factory Worker Garment Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Harley Barnes ည Bertha Alkire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Patricia M. Grapes / Daughter 25233 Seven Rivers Cir., Land-O-Lakes, FL 34639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Department of Important: If any injury or Cumberland Crematory 11/15/2012 4 Donation 5 Other (Specify) Cumberland, MD Signature of Funeral Service 22. Name and Address of Facility Upchurch Funeral Home, 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiralion disease or condition resulting in death) preumenia Medical Due to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami and that initiated events Due to (or as a consequence of) physician are the burial-t resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending properties of the second se IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 🗌 Yes Yes 25. Was case referred to medica Be 28. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: ျပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after deau...

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68455 11,13,12 5 npleted cause of death (Item 23a) (Type, Print) VALS Willasbrook Boad, Cumber land, MD 21502 MD 941

Registrar
DHMH 17 Rev 06-2011

State

34 Mar

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month VOHRA KASAM BHAI 6:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7105 WINTER ROSE PATH COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) 218-75-9133 Director 1 🛛 M 2 🗆 F 98 11-01-1914 INDIA 1 end 2 should be filed within 72 hours efter deeth with the Maryland of Heelth and Mantai Hygiene.
Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HOWARD 1 Yes 2 No COLUMBIA 10f. Zip Code 10g. Citizen of What Country? Funeral 7105 WINTER KOSE PAKISTAN 21045 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married ğ Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: ASIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AGRICULTURE SELF EMPLOYED 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ MUHAMMAD BHAI VOHRA AMINA BAI VOHRA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 WINTER ROSE PATH, COLUMBIA, MD- 21045 MUHAMMAD I. VOHRA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Depertment of I
Importent: If It
eny Injury or of 1 X Burial 2 Cremation 3 Removal from State LAUREL MARYLAND 11-12-12 MARYLAND NATIONAL 4 Donation 5 Other (Specify) 22. Name and Address of Facility HUSS AW'S ISLAMIC FUNERAL SERVICES PA 21. Signature of Funeral Service Licensee M 01388 9150 LANHAM SEVERN Rd, LANHAM, MD-20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ debility disease or condition Medical resulting in death) Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir After this certificete has been signed by the ettending physicien end fruerai director, pege 2 should be deteched for use as the buriel-transit or Attending Physicien: The lew requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No ours efter death. erel Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours e
To the Funerel C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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Corumbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges Clinton 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral 633-34-7917 Director 1 □ M 2 🖾 F 64 Dec.31,1947 Saigon and Merital Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗆 No Montgomery Silver Spring 10e. Street and Number 10g Citizen of What Country? Funeral 1119 Tiffany Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Vietnamese Vietnamese 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked of မ Vuong Unk. Ann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
302 Maranes Circle
Maumelle, AR 72113 19a. Informant's Name/Relationship (Type, Print) Ali Tran/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/1^{Date} permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 EXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd.,Suitland,MD.20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician (01505 tov Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and defected for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No After this certificate 2 1 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier -6el, MI 1020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Francisca Diane Vasquez Physician/ Nov. 1, 2012 1730 Medical 4c. County of Death
Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 6502 Mallery Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 M 2 TXF Months 1271 24 Tag 61 Guatemala 215-33-4554 50 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State with the Maryland Director Frederick MD Frederick 1 ¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21703 USA 6502 Mallery Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ≚Yes 2 □ No Guatemalan 5 pecify: 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Certified Nursing Asst. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H trant: If item 27 is marked ot jury or other traumatic even မ Petrona Avila Esteban Vasquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6502 Mallery Court Frederick, Maryland 21703 Yvette Urizar/Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/10/2012 Nosaceefritos: Chiquimulilla, Santa Rosa, Gua<u>temala</u> 1 X Burial 2 Cremation 3 X Removal from State Municipal Cemetery 4 Donation 5 Other (Specific . Signatur X Fungral Service Lig PHYTTE TIPACTORS RINIALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Breast Cancer 8 mo. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burightansit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 🗆 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 2 🔀 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending X Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) NOV 05 2012

32. Registrar's Signature Barres

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shannon O'Connor MD 9707 Medical Center Dr. #300 Rockville, Md.

D73109

November 2,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ronald Roston Utah Williams Medical 2013 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICU Medical PENINSULA 312/3041 REGIONAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Director 212-40-9840 1 X M 2 - F 71 01/16/1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Directo 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Marquis Avenue 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) retired radiologic technologist Veteran's Hospital 5+17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked otteny injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Sewell Williams India Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719~Marquis~Avenue~-~Salisbury,~MD~21801Victoria Williams/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Eastern Shore VA Cm | 11/14/2012 | Hurlock, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Jolley Memorial Chapel 1213 Jersey Road - Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
M (N WTES Immediate Cause (Final Pnysician/ MYDCAPOIN Suspected disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NIDOM Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events pue to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERU PLDEMIA HYPERVENS 10 H 1 🗌 Yes 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ves 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 욛 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mayner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MP 13 VÁ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ 12:05p.M November Lois White Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince Georges Caring Cove Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 04/02/1911 Virginia Director 60 5279 1 M 2 K F 101 Usual Residence of Deceden ar then "nature!", or items 23e or 28e-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Funeral Director 1 Ves 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20017 736 Buchanan Street, NE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 2 years Clerk Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be filed ent of Health and Mental H nt: If item 27 is marked ot y or other traumatic even Carrie Clark Moses Leftwich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Buchanan St., NE Washington, DC Rosa L. Chapman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it eny injury or o 1 Removal from State Maryland National Cem 11/13/2012 Laurel, Maryland 4 Donation) 5 Other (Specify) 21. Şignature of Funeral Service III nsee 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street, NE Washington, DC 20017 Men a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final Physician Debility disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin ig physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 19 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛅 Unknown Cerebral Vascular Accidents (multiple) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 2 🔁 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide work? 1 Yes 2 No injury 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

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Registrar

DHMH 17 Rev 06-2011

State

29a. Certifier

only one)

29b. Signature and title of certifier

Jocelyne

Jocelyn Kouatchou,

Kouathou, mo

MD 4041 P

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4041 Powder Mill Road, Calverton, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

20705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State o	of Marylar	•	artment of F tificate of D			giene Reg. No. 2	112	38794
	/sicia		1. Decedent's Name Rolar		,	Wallac	e			2. Date of Dea Month	pr Day 3	2012	3. Time of Death 12.56 km
	Medic amin		4a. Facility Name (if Doctor's				11	4b. City, Town, or Lan	Location of Death	111010	4c. County of Death Prince George		
	eral ctor		5. Social Security Nu 213-86-7	7884	6. Sex 1 IX M 2 □ F	7. Age (In yrs. 4 5	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 5 / 12 / 1	v, Year)	9. Birthpl Count	ace (State or Foreign y)
ryland -f show	ed at	ctor	Usual Residence of 10a. State	10b. County	e Georg		ty, Town or Loc		<u> </u>			10	od. Inside City Limits
ith the Ma 23a or 28a	st be notif	Funeral Director	MD 10e. Street and Num 12914 V	nber	ook Dri			10f. Zip Code 2073	5		10g. Citizen o		
INIC X IX ID-UUJO be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho	other traumatic event, the Medical Examiner must be notified at	ò	11. Marital Status 1 X Never Marri 3 Widowed	ed 2 🗆 Marr	12. Was Dece	edent Ever in U. rces? 2 No	li li	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	BI	ace - America ack, White, e _{fy} B1acl	tc.
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e, Mc and 2 sh Health ar tem 27 is	ther trau		LeTrisha	a D. W	allace- ister		129	14 Wind	brook D	r. C1:	inton,	MD 2	20735
Daltimor permit. Page 1 Department of Important: If it	jury or		1 🔲 Burial 2 🛭 4 🖾 Donation	Cremation 5 Other (S		State	cemetery, crem cro. C	natory or other placer	y 11/	13/12	Alexa	ndria	ı, VA
Depar	any in			den 9	. Seeve	P						Home Fred	i.,MĎ20678
Physic Med	ian/ lical		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List o Final	a.	ich litz	te 14	r the mode of dying					Approximate Interval Between Onset and Death
Exam		ner	Sequentially list cor	nditions,	b. Due to	or as a conseq	luence oi).						
ate be executed ohysician and	ial-transit	Examiner	if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	3	c. Due to	(or as a conseq	uence of):						
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the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. The Funeral Director: After this certificate has been signed by the attending p	iched for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 Live	come of pregna Birth 2 Fet nant at time of nown	al death 3	Ectopic pregnanc Other (specify)	у			Date of delive Month	y Day Year
requires that t	pe d	þ	Part II. Other signifi	cant conditio	ns contributing to d	eath but not res	sulting in the u	nderlying cause giv	ren in Part I.				e cause of death?
The law re		Completed								24a. Was a autop perfo 1 Yes	rmed2		sy findings available apletion of cause of
Physician: The lav	al director	FO B	25. Was case referre examiner? 1 Yes 2	No		Inpatient 2		Oth	ace of Death <i>(Chec</i> er: 4 Nursing Ho	ome 5 Resid	lence 6 🗆 Ot	ther (Specify)	
eath.	the funera	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investig 6 Could r	ation	of injury th, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe h	ow injury occu	rred	
tal or Att	lled in by		4 Homicide	determi	ned 28e, Place buildi	ng, etc. (Specif	y)	et, factory, office		28f. Location (S City or Tow	n, State)		
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this	npletely fi	Medical	(Check 2 only one)		Physician: To the beaminer: On the bas Norse Practitioner	sis of examinatio	n and/or invest	igation, in my opinio	n, death occurred a	it the time, date a	nd place, and c	lue to the cau	se(s) and manner stated.
Towit	CO		29b. Signature and	itle of coffifie	~			29c. License	70967		29d. Date sign	ned (Month, D	ay, Year) 2012
drugt	1		30. Name and addre	nit W	no completed caus	8118 (rook		sol La	nhim	MD.	20706	
Reg	State gistra	~	31. Date filed (Month	n, Day, Year) NOV	13 2012	egistra s Signa	eture A.	pares					

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			_ FOI	epartment of Health and N	Mental Hygie	ene 2012 38795							
			Registrar	Certificate of Death									
П	Physicia	in/	1. Decedent's Name <i>(First, Middle, Last)</i> James William Willis		2. Date of Death November 3 2012 3. Time of D								
×.	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November	3 2012 5:01 p M							
	Exami	ier	5530 Thompsontown Road	East New Mark	et	Dorchester							
96.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo		8. Date of Birth	Birthplace (State or Foreign							
	Director		216-54-7556 1 № M 2 □ F 62 Yrs	1 1 1 1	Dec. 2,	1949 North Carolina							
1	how at	٦.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits							
1	affylar 3a-fs iffied	Director	MD Dorchester	East New Mar	ket	1 ☐ Yes 2 🕱 No							
R	or 28	اقا	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?							
63	s 23a	Funeral	5530 Thompsontown Road	21631		USA							
-	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Armed Forces? 14. Race If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)												
36	is filed within 72 hours after death with the <i>Nativ</i> jand tal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1 Year or Dates, Vietnam	1 ☐ Yes 2 ☑ No Specify:		Black, White, etc. Specify: White							
21215-0036	hours hatura ical E	Completed	15. Decedent's Education 16a. De	ecedent's Usual Occupation	16	Sb. Kind of Business/Industry							
215	n 721 e. ian "r Med	mp	(Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4 or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ing	,							
21	withi		12	disabled		did not work							
Maryland	be filed within 72 hours after death with the natal Hygiene. ked other than "natural", or items 23a or 2 cevent, the Medical Examiner must be no cevent,	To Be	17. Father's Name (First, Middle, Last) James H. Willis		ne (First, Middle, Maid	den Surname)							
Σ	d Mer mark mark	-		Jean P									
Ma	2 sho Ith an 27 is I			lailing Address (Street and Number or Rur 22 Cinnamon Lane, L									
ē,	age 1 and 2 should be file nt of Health and Mental H t: If item 27 is marked of or other traumatic ever		20a. Method of Disposition 20b. Place of Di	sposition (Name of		c. Location - City or Town, State							
altimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		T Bullal 2 La Cremation 3 Li Removal nom state	crematory or other place) rv of Delmarva 11/	6/12	Delmar, DE							
alti	rmit. I spartr ports y inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Tho	mas Funera	al Home P.A.							
8	2 2 E E O		Dr. T	700 Locust St., Ca	mbridge,	MD 21613							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death										
3-	hysician/ Medical		disease or condition resulting in death)	ic Pancrealité	7	Yens							
البسا	Examiner		Due to (or as a consequence of):			(
		ner	Sequentially list conditions, if any, leading to immediate cauce. Enter thoughths										
	d d ansit	Examine	Cause (Disease or injury that initiated events c.										
	ate be executed hysician and the burial-transit	ĕ	resulting in death) Last Due to (or as a consequence of):										
09	death certificate be executed he attending physician and ed for use as the burial-transi	dical	d										
687	e death certifica the attending pl hed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy										
Вох	ath ce attend for us	cian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year							
	the de by the tached	hysi	1 Yes 2 No 4 Pregnant at time of death 9 Unknown										
P.0	that ned e de	by P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobac	cco use contribute to the cause of death?							
	v requires that s been signed t should be det	ted t		seen, Liver	1 🗌 Yes	2 ☐ No 3 Probably 4 ☐ Unknown							
Sor	has bei	plet	cirrhosis, Asthma, Tobacco	rbuce,	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
Rec	The ate pag	Completed	Thrombocy to fema, hyper lifedomia	•	performed								
ta	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)								
of Vital Records,	Physi this c ral dir	은	1 ☐ Yes 2 ₩ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outps 27. Manner of Death			e 6 Other (Specify)							
n 0	ding F th. After funer	cate	1 ★ Natural 5 □ Pending (Month, Day, Year) injur		28d. Describe how i	njury occurred							
isio	Atten ir dea ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,			at and Number or Rural Route Number,							
Division	ral or s afte al Dire		building, etc. (Specify)		City or Town, S	tate)							
	To the Hospital or Attending Physician: "In this 24 hours after death and the Funeral Director After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in										
	To the P within 24 To the F complet	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowle 29b. Signature and title of certifier	dge, death occurred at the time, date and pl	ace, and due to the ca	ause(s) and manner as stated.							
_	6 ≧ 6 8		29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)							
	1/1/		30. Name and address of person who completed cause of death (Item 23a) (Type	Doo 52255		1-05-2012							
	W.		Muhammad Eiaz 830 Chocal	eake Dr. Cambria	22, MD	2/6/3							
	Sta	te	31. Date filed (Worth, Day, Year) 32 Registrar's Signature	6.41									
	Registra	ar	NOV 98 2012 Breeze A. A	Pave									

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Washington

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Redistrar's Signature

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K. R. 55

Susan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Ernest Jefferson Wolf, Jr. November 5, 2012 5:45 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Carroll County **Examiner** 4b. City. Town, or Location of Death Westminster Golden Living Center Social Security Numbe Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 25, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 217-24-4507 Maryland Director 1.**X** M 2 □ F 83 1929 28a-f show 10b. County 10a. State 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director Maryland Baltimore County Catonsville 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2 Overbrook Road 21228 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give ð Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify white "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) chemical manufacturer other traumatic event, the engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eileen Buckle Ernest J. Wolf, Sr. and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Kennys Hill Drive Westminster, MD 21157 permit. Page 1 and 2 sl Department of Health al Important: If item 27 is any injury or other trau Sandra L. Differ / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20c. Location - City or Town, State Date 6 Nov. 1 Burial 2 X Cremation 3 Removal from State Hampstead, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Eline Funeral Home 21. Signature of Funeral Service Licen 22. Name and Address of Facility 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or Injury that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a signed by t d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn Yes 2 No 1 🗌 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ours after death.
eral Director: After this filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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31. Date filed (Mor

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address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

K. BERNE

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2012

			For 1 ≃ State Registrar	State of Maryland		artment of F tificate of		d Mental Hy	rgiene	12	38798	
		4	Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death	
	Physici /Medic		Nyatie Edith	WARTIELD				Month 1	O3.	Year 2012	420 PM	
	Examin		4a. Facility Name (If not institution, give	treet and number)		4b. City, Town, o	r Location of De	eath	4c. Coun	ty of Death		
	•			SISTED LIVIN		Westr				4 1011		
п	Funeral		5. Social Security Number 6. Sex	/-	t Birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. (Month, D.	ay, Yeer)	9. Birth	place (State or Foreign ntry) VICGINIA	
	Director		220-20-3663 1L Usual Residence of Decedent	86				o vo	8 1926		The state of	
	yland now		10a. State 10b. County	10c. City, 1	Town or Lo	cation					10d. Inside City Limits	
	Mar-fish	ţċ	MD Carroll	Wes	tmin.	ster					1 ☐ Yes 2 No	
	or 28	lre	10e. Street and Number			10f. Zip Code			10g. Citizen o		ntry?	
	death with the Maryland ms 23e or 28a-f show rmust be malified at	Funeral Director	4113 Ridge Road			2115			U.S.A			
	ter deal	nue		12. Was Decedent Ever in U.S. Armed Forces?	13.	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or Note to Rican, etc.)	0- 14. Ra Bi	ace - Ameri ack, White,		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		I ☐ Yes 2 🕱 No	Specify:		Spec	ity: Win	ite	
5-0036	72 hours after natural', or Ite		15. Decedent's Edu		16a. Deced	lent's Usual Occup	ation		16b, Kind of	• •		
215	within 72 ene. then "na	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done OO NOT use retired	during most of (d)	working		1		
2121	d with giene er the	Completed	12	College (1 401 51)	Su	pervisor			Phone	e (com	pany	
	be filed tal Hygid d other event. II	Be (17. Father's Name (First, Middle, Last)				i i	Name (First, Middle		ame)		
yla	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the M.	၉	Eugene F. King				Lavie	W -157	nents			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other then "netural", or Items 23e or 28e-f show other treumatic event. The Modical Exp., in or trust the indifficular of		19a. Informant's Name/Relationship (Ty Sharon Sullivan			dumbert		Rural Route Numb	-		D 21158	
	es 1 and 2 of Health item 27 i		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	- 1	Date	20c. Location			
nor	ages int of t: If it f or o		1 Burial 2 Cremation 3 R	emoval from State cem	etery, crer	natory or other place		ember 8, John	(other	J E	on.	
Baltimore,	permit. Pages Department of I Important: If ite eny injury or or		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			. Name and Addre	1	Chrock of a like	octib	00/19 1	Р	
B	permit. Departr Importa eny inji		Deterben K Mil	(2)	Pe.	ters funeral	Homa, Inc.	34 Carlisti	street be	HYSSUM.	PA 17325	
	25		23a. Part1. Enter the disease, or compli	cations that caused the death.	Do not ent	er the mode of dyir	ng, such as card	diac or respiratory a	arrest,	1	Approximate Interval Between	
4	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
	/Medical		resulting in death)	Due to (or as a consequen	ce of):	1.7219	013				2008	
	Examiner	_	Sequentially list conditions,	Avenua							2008	
	ed Isit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice of):						2	
	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					11	2009	
8760,	icate be executed physician and s the burial-transit	dlcal E		People 1	11 ce	P dis	case				2008	
89	ificate g phy as the				A1 C							
Box	death certifii e attending p id for use as	In/M	230. Was decedent pregnant	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy	,			ate of deliv		
	0 0 2	sicia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of deat		Other (specify)	· 		, ,	Month	Day Year	
P.0	at the by the stach	Phys	9 Unknown									
	requires that the death een signed by the atter rould be detached for r	Completed by Physician/Me	Part II. Other significant conditions cor	· ·	ng in the u	nderlying cause giv	en in Part I.		Yes 2 No		the cause of death? bably 4 □Unknown	
orc	v require been sig should b	ted	Senile den	DENTIA-				-				
Records,		mple						24a. Was	s an 24b opsy ormed?	prior to co death?	opsy findings available empletion of cause of	
alF	n: The licate ha							1 Yes	2.0 No	1 🗆 Yes	2□ No	
Vital	Physicien: The la r this certificate has ral director, page 2	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ EP	VOutnation	t 3 DOA Oth		Death (Check only g Home 512 Has		ther (Speci	Asst.	
of	ding Phy h. After this funeral o	n: To	27. Manner of Death		b. Time of				how injury occi		" LIVIII	
ion	Attending I r death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No					
Division	r Atte er de recto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location	(Street and Nur	nber or Rur	al Route Number,	
	ital or ris aft rel Di	Cer										
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certification;	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination	edge, deat! n and/or in	occurred at the tire vestigation, in my control	me, date and pla pinion, death o	ace, and due to the ccurred at the time	cause(s) and r , date and place	manner as : e, and due t	stated. to the cause(s)	
	thin 2 the or the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	a number		29d. Date sign	ned (Month,	Day, Year)	
	, 5.≧5.8 =		Dumous	Karoun X.	4.0		Zuen	7	11/0	, ,	2012	
	SC		30. Name and addless of person who co	mpleted cause of death (Item 2)	3a) (Type	Print))		/	1/		
	10		41 /agua u	lay. Westi	250	d	d. 01	157 . 5	imone Bra	vb		
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signatur		6-41						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 2:32 PM leager Medical 4a. Facility Name (in not institution, give street and nomber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Autumn Assisted Living Hagerstown Nd Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral May 177, 1931 Days 1 - M 2 X Hours 214-28-0667 81 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits with the Maryland Director Maryland Washington Hagerstown 1 X Yes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a 310 Cameo Dr. 21742 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Was Deceue:: ____ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Reality Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Sword Pearl Carbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Village Place Hagerstown, MD 21742 Health a Michael J. Yeager-son permit. Page 1 and 2 Department of Health Important: If item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 11-13-2012 Hagerstown, MD 20a. Method of Disposition ō 1 XBurial 2 Cremation 3 Removal from State injury (4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 2. Sign were of Funeral Service Licenses any 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No ed by the a g Unknown g Unknown nas been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autonsy page death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 6 Other (Specify) Hospital 2 - No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number R093556 29b. Signature and title of certifie

State Registrar 30. Name and address of person w

o completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Confidence Con				For	State of Maryland / Depa	artment of Health and N	lental Hygiene		
Physician Medical Examiner 10. Service Control Medical Service Control Medica		_			Cer	Reg. No. 2012 3880			
Examiner Common	2		_	1. Decedent's Name (First, Middle, Last)	sin UME	<i>s</i>		Year 1630 M	
Proportion Pro				11.1. 1	o Has DIN MIL	4b. City, Town, or Location of Death			
The part of the	12			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)	
Security Security		A.		Usual Residence of Decedent	/		10-29-2012		
Security Security		Marylan 28a-f sh otified a	recto	MD PEINER	0	MARRONTON			
Security Security		with the 23a or 2	eral Di	10e. Street and Number	he	10f. Zip Code	10g. Citizen of	What Country?	
Bengalawing good and good of the property of t	920	s after death v al", or items Examiner mu		1 Never Married 2 Married	Armed Forces?1 If 1 Yes 2 No If Yes, Give 1	Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Blac	ck, White etc.	
The figure of the continuence of the control of the	1215-0	thin 72 hours ene. than "natur he Medical	Somplete	(Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Deced	kind of work done during most of work O NOT use <u>retired</u>	16b. Kind of B	usiness/Industry	
190. Mailing Address (Strest and Number or Rural Route Number of R		e filed tal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)	The la dillian	18. Mother's Nam	e (First, Middle, Maiden Surnam	to Untes	
20a. Method of Disposition Burna 2 Contraction 3 Reproval from State Page 2 2 2 2 2 2 2 2 2	laryk	should and M is mar aumat		~		g Address (Street and Number or Rura	al Route Number, City or Town, S	State, Zip Code)	
23a. Part. I. Erret rhe disease, or cympications that caused the death. Do not errier the mode of dying, such as cardiac or respiratory arrest, Medical Examiner Medical Exa		1 and 2 of Health item 27 other tr	4	20a. Method of Disposition	20b. Place of Dispos		Date 20c. Location	- City or Town, State	
23a. Part. I. Erret rhe disease, or cympications that caused the death. Do not errier the mode of dying, such as cardiac or respiratory arrest, Medical Examiner Medical Exa	Itimo	iit. Page artment o ortant: If injury or	1	4 Donation 5, Other (Specify)	toptal Disp trince (reorgestapital "	7 7	rerly, UD	
Immediate Cause (Final death) Medical Me	Ba	Deprilement of the concession		mater fir	sm 3	001 Hospital Dri	ve Cheverly	UD 10785	
Medical Examiner Page Pag	.c.P	flysician/		Immediate Cause (Final	ations that caused the death. Do not ente cause on each line.	The t	or respiratory arrest,	Interval Between	
Due to (or as a consequence of): Comparison of the control of t					Du to (or as a consequence	nature Rushas	a mentra	a co	
POR CO 15 June 20 June		sit sit	niner	if any, leading to immediate cause. Enter Underlying	0 + 0.	5			
FFEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Donoton Birth 2 Donoton Bi		execute ian and urial-tran	ıl Exar	that initiated events C.		amnonin			
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Security Security	E .	in: The tificate tor, pa	Ф	25. Was case referred to medical		26. Place of Death (Chec		1 ∐ Yes 2 X No	
Security Security	. Kits	ysicia is cert direct	100		spital:	Other:		er (Specify)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	n of	ing \fter \une		1 Natural 5 Pending		work?	28d. Describe how injury occur	red	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Divisio	al or Atter s after dea Il Director ed in by th		3 Suicide 6 Could not be		eet, factory, office		er or Rural Route Number,	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 10/30/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Hos 14 h Fun Fun tely	Medica	(Check 2 Medical Examine	r: On the basis of examination and/or invest	igation, in my opinion, death occurred a	t the time, date and place, and du ace, and due to the cause(s) and i	e to the cause(s) and manner stated. manner as stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		No the within to the comp	2		> MD	29c. License number	29d. Date signe	d (Month, Pay, Year)	
	U	1 1/1		30 Name and address of person who con	npleted cause of death (Item 23a) (Type, P	Print)	2010	- / / //	
State Registrar NOV 3 0 2012 State Registrar					32/Registrar's Signatur	wive chevery r	n1) au/85		

/lyrna	Zelaya-Quesada	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar		eg. No. 211	2 3880					
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Myrna Iris Zelaya — Quesada	2. Date of Death Month Day Year November 16, 2012 3. Time of Death 1717 hrs							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death						
,		17 Friendship Drive Friendship		Anne Arundel						
Funeral Director		5. Social Security Number 219-17-4128 1 Months Days Hours Min.	_	rth(MM/DD/YYYY) 9. Bin Foreig Co						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
and show	ь	MD Anne Arundel Friendship			1 Yes 2 X No					
th the Maryland 23a nr 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Country?						
vith the		17 Friendship Road 20758 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No	U.S. A.	can Indian Black					
death v	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No		White, etc.	our maian, black,					
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5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of votaring most of working life. DO NOT use retired to the control of th		16b. Kind of Business/I	ndustry					
vithin 7 ene.	a m	5+ Journalist		U.S. Gove	ernment					
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a nr 28a-f she r traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) Mario Antonio Zelava - Najera Myrna		A ALE STREET						
2121: ould be fill marked ic event,		Mario Antonio Zelaya - Najera Myrna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Iris Rural Route Nur	Quesada mber, City or Town, State	Zip Code)					
Imore, MD 2 Pages I and 2 shoul ment of Health and M sant: If item 27 is m or other traumatic		David W. Oswald, III, husband 17 Friendship Road, F								
Ore,		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 11/	Date	20c. Location - City or						
Baltimore, permit. Pages I at Department of Her Important: If ite injury nr other tr		4 Donation 5 Other Specify: PletTopOlitan Crematory 11/ 21 Sunature of Funeral Service Licensee 22. Name and Address of Facility Rat	22/12	Alexandria	· .					
Depu Depu		Lyan & Telach 8325 Mt. Harmony I			20736					
Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and					
xaminer	Contract Company Have 1 of the work									
The same of the sa		Sequentially list conditions, b								
	in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Chicago in intent to initiate a								
isi ed	Examiner	events resulting in death) Last Due to (or as a consequence of):								
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical	d ✓ UNPENDED ✓ AMENDED 23a,27,28a-f,per me,g936 2-6-13	3 sm							
760, icate be physic		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
Box 687 he death certific the attending in hed for use as it	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	incy	Month D	ay Year					
BO, he deat	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Lag. Bile							
Division of Vital Records, P.O. tal ar Attending Physician: The law requires that the rs after death. 11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to s 2 No 3 Prob						
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OD C	Certification:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No		shot self						
ivisi nr Att after de Direct	E E	3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru State) 17 Friend:	ral Route Number, City					
D nspital hours nneral		4 Homicide determined (Specify) Home	Friend	ship,MD.						
Division To the Haspital or Attend within 24 hours after death To the Faneral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at								
F 2 F 8	Æ	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	oth, Day, Year)					
		froder II, ling Style, D.		November 20, 20	12					
		 Name end address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B. 	altimore. MI	D 21223						
Sta	ate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature								
Regist	rar	NOV 2. 9 2012 Denus D. Jacks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38802 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:42 Frances Marie Wisniewski Adolph 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Months Hours (Month, Day, Year) 216-12-0450 Director 1 - M 2 X F 91 Yrs October 1,1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 United States 2300 Dulaney Valley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed Specify: white 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 homemaker own home Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any linjuy or other traumatic event ONG. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline (unknown) (unknown) Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Sugar Tree Place Cockeysville, MD 21030 Katherine Adolph/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardDec. 3, 2012 | Timonium, Maryland 21. Signature of Funeral Service Licensee ያሪስት ማርያ ያስተማሪካ ያመደረገ John Tuneral Services of Dulaney 200 E. Padonia Rd. Timonium,MD 21093 Valley, P.A Valley, P.A. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh //, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be
 At bours after death.
 I-uneral Director: After this certificate has been signed by the attending physicis
 Innerel Director. After this certificate has been signed by the attending physicis
 retering the funeral director, page 2 should be detached for use as the bu
 Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specily) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 🗶 Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hou To the Funer completely fi (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29d. Date signed (Month, Day, Year) 2012

State

p.m.

2012

Registrar
DHMH 17 Rev 06-2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year) . -

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tace 70125 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5. Social Security Number 1/6 If Under 1 Year I If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🔀 F Days Hours 214-19-1930 82 Yrs. **Director** 07/19/1930 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location **Funeral Director** must be notified Sykesville Md. Carroll ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 5411 Emerald Drive 21784 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Health and Mental Hygiene. the Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred R. Hoffman Sr. Katherine Ricktor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 Emerald Drive Sykesville, Md. 21784. Barbara G. Wallace (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 K Cremation 3 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 11/30/2012 |Svkesville,Md. Signature of Papers Service License 22. Name and Address of Facility Haight, Funeral Home & Chapel rlille Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Pregnant at time of death the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an has autopsy performed? Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ျှ 2 **N**0 Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending I after death. 24 hours after death. Funeral Director: After Natural 5 Pending work? 1 Yes Accident Investigation filled in by the Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) catifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number **34849**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1645 Liberty Rd Eldersburg

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate

Interval Between

Onset and Death

1 Tes 2 No

Country)

Year

Black, White, etc.

White

Registrar DHMH 17 Rev 7/2009

State

who completed cause of death (Item 23a) (Typę, Print)

MD

Jan

31. Date filed (Month, Day, Year)

amend item 20a-c per fh 934 12 18-12 wet State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KENNETHM. BONNER Month V Year 2012 06.55AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 214-64-7236 Country) Director 1 XM 2 □ F 56 Yrs. 11/14/1956 MD i Hygiene. other then "neturel", or items 23e or 28a-f show vent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 Eberle Dr. U.S.A. 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Store Elementary/Secondary (0-12) 12th College (1-4 or 5+) Sal. Army Thrift Management e 1 end 2 should be filed wit of Heelth end Mental Hygie If item 27 is merked other or other traumetic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Bonner Marion Levronev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Wilson (Brother) 6610 Eberle Dr. Baltimore, MD 21215 Baltimore, 20b. Place of Disposition (Name of Mcemeters crematory or other place) 20a. Method of Disposition permit. Pege 1 e Depertment of H Importent: If its eny Injury or ott 20c. Location - City or Town, State 1 Burial 2 Removal from State Lansdowne 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22 Jorse Midrest of Family Own Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INER Physician/ week Medical resulting in death) Due to (or as a consequence of): Examiner YEARS. MYELOMA MULTIPL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physicien end I for use es the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the Innoral director, page 2 should be deteched for use as the burial-transit DISSEMINATED INTRAVASCULAR COAGULATION Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64583 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NRPAMA D MITIKIRI OF MARYLAND 22 S.GREENEST. UNIVERSITY MEDICAL CENTER BALTIMORE, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Therese Brengle November 2012 11:58 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Months Hours (Month, Day, Year) **Director** 220-22-3391 1 □ M 2 🗓 F 84 Jan 27, 1928 Maryland be filed within /2 II-C...
lental Hygiene.
Irked other than "natural", or items 23a or 28a-f snow
Irked other than "natural", or items 23a or 28a-f snow
Irke event, the Medical Examiner must be notified at 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d Inside City Limits Director MD Baltimore 1 Yes 2 No Glen Arm 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11630 Glen Arm Road 21057 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. white 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) should be filed with h and Mental Hygien 7 is marked other t office manager fruit package company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Richard Walpert Connell Alice Evelyn McMahon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Lewin/son 1 and 2 s of Health item 27 9 Teaneck Court Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Poneral Service Licensee Rona 10 8 M 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 rector 23 1 art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. Interval Between Onset and Death Immediate C se (Final disease or condition Physician/ 1BOVRAL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi Due to (or as a consequence of): i signed by the attending physician Id be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORDO Records, cate has been sig 1 🔲 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 8 26. Place of Death (Check only one) examine?
1 Pes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) + SP1 (ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral (28a. Date of injury (Month, Day, Year) 28c. Injury at To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident un Known 5 Pending work? 1 ☐ Yes 2 🗖 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) //630 624 557 determined Hamp NUISING Medical Lentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who comp

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2012

eted cause of death (Item 23a) (Type, Print)

Con M

Registrar's Signat

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			For State Registrar		Otate	or ivial ylar		tificate of		id Workari	Reg. No.20	2	38806
	Physicia Medic		1. Decedent's Name	Firsh Middle,	ast)	Berr	1			2. Date of D Month	eath	12	3. Time of Death
	Examin		4a Facility Name (if		give street and n	umber)		4b City, Town	, or Location of D	Peat) - L	C. County of	Death	· C ba
	Funeral Director		5. Social Security No	.6523	5. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes Months Day			irth gay, Year)	* 1	ce (State or Foreign
	land show dat	tor	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Loc				<u> </u>	100	d. Inside City Limits
	he Mary or 28a-f notifie	Director	10e. Street and Nun	nber 1			saltin	nore	e		10g. Citizen of Wha	t Countr	1 ☐Yes 2 ☐ No
	h with t ns 23a nust be	Funeral	2406 6	W. Co.	ld Spr		ne		2121		L	154	7
980	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Marri 3 Widowed		12. Was De Armed 1 Yeif Yes, C			/as Decedent o Yes, specify Co		? (Specify Yes or No uerto Rican, etc.)	14. Race - Black, \ Specify:	American White, etc	
21215-0036	72 hou in "natu Medical	Completed		15. Decedent'	grade complete		(Gires k	ent's Usual Occ ind of work dor NOT use retire	ne during most of	yorking	16b. Kind of Busin	ess/Indu	stry
	ed within Hygiene. other tha ent, the I	Be Co	Elementary/Spcc	th		(1-4 or 5+)	Je	curit	y Off.	cer	Secu	nt	4
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, Maryland	1 and 2 should be filed within 72 hour if Health and Mental Hygiene, item 27 is marked other than "natun other traumatic event, the Medical		19a Informant's Na	ame/Relationship	(Type, Print()	Nother)	19b. Mailing 2400	g Address (Sre	et and Number b	r Rural Route Numb	Baltime	zip Cor	21215 mb
altimore,	0 4- 2-		20a. Method of Disp	oosition	Removal fro	om State	Place of Dispos cemeters, crem	atory (Name of atory of other p	olade) 9	128/12	20c. Location - Cit	y or Tow	n, State
Baltir	permit. Page Department Important: I any injury o		21. Signature of Fur	neral Service Lic		0.40	22	Warren !	drans of Cability	Greene	Funeral	Se	rias
			23a. Part 1. Enter t shock, or hear	ALVV C	omplications tha	at caused the dea	th. Do not enter	the mode of d	dying, such as car	diac or respiratory	arrest,		approximate nterval Between
	Physician/ Medical		Immediate Cause (disease or condition resulting in death)	Final	a	the	J Ma	Dula					Inset and Death
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m ^c	uted id ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nmediate rlying injury	Due t	to (or as a conseq	quence of):			D M	BY MEDICAL EXAMINER		
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日 Box 6	the Hospital or Attending Physician: The law requires that the death certificate in 24 hours after death. The Lunear Director: After this certificate has been signed by the attending phys impletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknow	months?	1 ☐ Liv 4 ☐ Pr	outcome of pregn ve Birth 2 Fet regnant at time of nknown	al death 3	Ectopic pregn Other (specify,			23d. Date o Month		ay Year
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ord ord	w requir s been s 2 should	Completed	Še	ind	re d	102 il	der			24a. Wa	s an 24b. Wer	e autops	y findings available pletion of cause of
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Vital	is certif directo	To Be	25. Was case referre examiner? 1 A Yes	No medical	Hospital:	Inpalient 2	ER/Outpatient		Dther: 4 Nursi		sidence 6 Other (S	Specify)	
n of	nding PI tth. : After th e funeral		27. Manner of Death 1 Natural 2 Accident	h 5 ☐ Pending Investiga	(M	te of injury onth, Day, Year)	28b. Time of injury	W	njury at vork? ☐ Yes 2☐ No	28d. Describe	how injury occurred		
#23 Division of Vital Records	il or Atter after dea Director d in by th	Certificate:	3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Pla	ice of Injury - At h Ilding, etc. (Specif	ome, farm, stre (y)	et, factory, offic	ce		(Street and Number o	r Rural R	oute Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 (Check 2 only one) 3	☐ Medical Exa	aminer: On the b	pasis of examination	on and/or investi	gation, in my op	oinion, death occu	rred at the time, date	cause(s) and manner and place, and due to the cause(s) and man	the cause	e(s) and manner stated.
	To the within To the Comp	~	29b. Signature and		2				ense number	7	29d. Date signed (A		
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K)	Registra	ar		DFC 03	2012	Double	A. A	acked					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 56 PM 2012 Archie Bartee Valenset Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11215 Youngstown Drive #710 Washington Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr 26, 1 **Funeral** Months Days 1 🕅 M 2 🗆 F Director 212-48-1016 65 1947 Marvland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Washington Hagerstown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 11215 Youngstown Drive #710 21742 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 M Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry unk permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other trainments. Elementary/Seconday (0-12) College (1-4 or 5+) computer programmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James W. Bartee Minnie L. Teel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Bartee/spouse 11215 Youngstown Drive #710 Hagerstown, Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signatur - Fuperal Sc 22. Name and Address of Facility nonala State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, be neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician rebrovascular Years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** lears Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transi The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Yes 25 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy this certificate has performed death? 1 ☐ Yes 2 No Yes 2 No or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 WResidence 6 Other (Specify) Hospital: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death.

uneral Director; After the filled in by the funeral Certificate: work? 1 Natural injury 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifi-

30. Name and address of person

31. Date filed (Month, Day, Year)

3

use of death (Item 23a) (Type, Print)

tagerstown

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4.32 AM Harry Bennett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Boltimore Medical Baltimore VA Center 8. Date of Birth (Month, Day, Year) 5/15/1919 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 042-18-1003 Director 1 M 2 □ F New York or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location illed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1101 Timber Trail Road 21286 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna N. Karlson Harry R. Bennett l and 2 should b f Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Bennett / daughter 1101 Timber Trail Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 12/3/2012 Towson, Maryland injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Juneral Service Licensee J. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ neumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). physician and s the burlal-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending I IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detended. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed unhan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifie 102528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore, 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 29 9:00 PM Physician/ Danuta Christina Borek 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Anne Arundel Heartlands Assisted Living If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 213-30-6018 **Director** 1 🗆 M 2 🗐 XF June 6, 1923 Poland Poland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 🗆 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8216 Bayside Drive USA 21122 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces 1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Seamstress other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ! ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 Bayside Drive, Pasadena, Maryland 21122 Agnes I. Whisenant - Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Meadowridge Mem. Park 12/03/2012 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. injury or Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaulman F.H. @ MMT 21. Signature Funeral Service Licens 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ Congestive heart disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by McChitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2: autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 30, 2012

State

31. Date filed (Month, Day, Year)

8601 Viterans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

FT WY

D57531

Just 204, Millersville, MD

12-08900 Peter Berges

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or waryland		ificate of		and went		Reg. No.		2 3881
Physicia Medical Examir		Decedent's Name (First, Middle,La Pete			A			2. Date of De Month	ath Dav Yea er 22, 2012		3. Time of Death 2213 hrs
		4a. Facility Name (if not institution, gi			4	b. City, To	wn, or Location of		4c. County 6	of Death	
		10801 Enfield Drive				Woods			Howard	J. B.	
Funeral Director		5. Social Security Number 6. S		(In yrs, las		If Under Months	1 Year If Under Days Hours	Min.	irth(MM/DD/YYYY	Foreign	New
		217-74-1688 1 L	<u>X</u> M 2 F	55	Yrs.			05-26	-1957		Jersey
w any		10a. State 10b. County		10c. City, T	own or Location	on					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ğ	MD Howa	ard			10f. Zip C		aurel T	10g. Citizen of Wh	not Coun	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10400 Derby Dr	ivo			101. ZIP 0	20723				States
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent	Ever in U.S	. 13. Was	Decedent	of Hispanic Origi	n? (Specify Yes or N	o- 14. Race	- Americ	can Indian, Black,
r death	Funeral	1 Never Married 2 X Marrie	1 Yes 2	X No		_	_	Puerto Rican, etc.)		e, etc.	• •
irs afte tural",	Ď	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates: only highest grade com	pleted)	-		No specify:	ind of work done	Specify: 16b, Kind of Bu		nite
5-0036 led within 72 hours a Hygiene. cother than "nature the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		during mo	st of worki	ng life. DO NOT u	se retired)			
within within grene.	d mo	17. Father's Name (First, Middle, Las	5+		Certi	fied		Accountant		ount	ing
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medical	Be C	William P. Berges						aria J. Cl		,	
2121 hould be fi in Mental is marked	٩	19a. Informant's Name/Relationship (Type, Print)				(Street and Numb	per or Rural Route Nu	ımber, City or Tow		
imore, MD 21215-003 Pages 1 and 2 should be filed withint of Health and Mental Hygiene. Itani: Witem 27 is marked other thorother transmatic event, the Med		Deborah A. Berges 20a Method of Disposition	s - wife	20b PI	10400 ace of Disposi			, Laurel,	Maryland 20c. Location		
Baltimore, permit. Pages 1 an Department of Hecumportant: Wite Injury or other training or other train		1 XXBurial 2 Cremation 3	_	ite cr	ematory or oth	er place)	,,			·	
Baltimore pernit. Pages 1 Department of H Important: If i	1	4 Donation 5 Other Specification of Funeral Service Dice		rieac	22. N	e Meli ame and A	ddress of Facility	Gary L. K	4 Elkri aufman F	age,	Maryland al Home at
E P P W		March 15	delin		MMP	, Inc	, 7250 V	Vash. Blvd	, Elkrid	ge,	MD 21075
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e		the death. [Do not enter th	e mode of	dying, such as ca	rdiac or respiratory a	rrest, shock, or he	art	Approximate Interval Between Onset and Death
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The same of		Sequentially list conditions,									
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	quence of):							
nsit	Exa	events resulting in death) Last	Due to (or as a conse	quence of):							
execution in and in and in and	Medical	X UNPENDED	AMENDED23a, pt.II, per	27, pe	г ле, g	934 1	2-6-12 s	sm			
760, cate be ex physician the burial	Med	IF FEMALE:	23c. If yes, outcon	me,g ne of pregna	934 12- ancy	-28-1	Z SM		23d. Date of	delivery	
Box 687; death certificate attending	Cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	time of deat	_ =	al death er <i>(Specif</i>		pregnancy	Month	D	ay Year
that the death certificate by the attending detached for use as the sate of th	Physician/	1 Yes 2 No 9 Unknow	a ouknown								
i, P.O.	by P	Part II. Other significant conditions	_	but not res	sulting in the u	nderlying c	ause given in Par	,,,,,,,			the cause of death? ably 4 Unknown
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COF te law r te has b ge 2 sh	ğ							perf	ormed?	death?	ompletion of cause of
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of Vital Records, ag Physician: The law require the true certificate has been sineral director, page 2 should be		1 Yes 2 No	Hospital: 1 Inpatie		R/Outpatient			Nursing Home 5	Residence 6		Scene
n of iding Ph		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inju (Month, Day,Y	ry ear)	28b. Time of Ir	ijury 28	c. Injury at Work?		how injury occurr	ed	
Division tal or Attendi rs after death. al Director: A led in by the fu	Eg	2 Accident Investiga 3 Suicide 6 Could no	28e Place of In	uгу - At hor	ne, farm, stree	t, factory, o	office building, etc		(Street and Numb	er or Ru	ral Route Number, City
Divinal o	Certification:	4 Homicide determin						or Town,	State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		(4.1.5.1.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.	cian: To the best of my er:On the basis of exam	_							
Tot Tot	Medical	29b. Signature and title of certifier	and manner stated				License number		29d. Date sign		
		1 X sendorlos	us)				O.C.M.E.		November	23, 20	12
		Mame and address of person who		•		161		MD 04000	1 -	-	
Ø √ St	ate	- 1 to	stant Medical Exa	miner s Signature		itimore S	street, Baltim	ore, MD 21223			
Regist	rar	31. Date filed (Modification, Year) 2	012 Sene	4	1. 40	Med					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2901 Kirk Avenue Raltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min. (Month, Day, Year) Director 1 🗆 M 2 🗷 F 217-64-5346 55 Md. Jul 21, 1957 Usual Residence of Dece 28a-f shov 10a State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 Kirk Avenue 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Welder **Construction Work** other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Brown Erma Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Butterworth 2901 Kirk Avenue. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eny injury or Dec 01, 2012 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final fancieatic cancer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has t director, page 2 s autopsy death? 2 🗌 No 24 hours after death.

Funeral Director: After this certificallely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes ျှ 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 ☑ Residence 6 ☐ Other (Specify) 27. Mannar of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MSRajapahlano 27/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Kajapa Ksem D 2835 Smith AV

Registrar

State

31. Date filed (Month, Day, Year)

5203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Beulah Month Year **ZO**l Bulett 26 8.34 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore led Star Harbor Hospital If Under **Funeral** . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year) $37_{Yrs.}$ **Director** 213-82-1687 1 □ M 2 🗓 F Jan. 14, 1975 Maryland Usual Residence of Decede iral", or items 23a or 28a-f show Examiner must be notified at 10b. Count the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore City 1X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 S. Carey St. 21230 United States "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) 12th Clerk Hospitalality/Motel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Billy Bulett Louise Lawless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 S. Carey St., Baltimore, Maryland 21230 Rhonda Haughie / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY Nov. 30,2012 Glen Burnie, MD nature of Fineral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Electrical disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year signed by the at d be detached fo g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obesity Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown Diabetes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2.4 No death? 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D0059707 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Baltimore Hanover St. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER Day 28 BERNSTEIN 3:05 P M JACK 2012 Medical Α 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days 218-66-1697 Director 1 X M 2 □ F 58 09/28/1954 MD or 28a-f shov 10a. State 10b. County 10c. City, Town or Location tha Maryiand 10d. Inside City Limits Director 1 Yes 2 1 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3408 TERRAPIN ROAD 21208 USA fliad within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witi Department of Health and Mantai Hygier Importent: If Item 27 is merked other tannatic event, the proce. 5+ ATTORNEY LAW æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEONARD BERNSTEIN **JOHANN** SEGAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN BERNSTEIN/BROTHER 12604 WATERSPOUT COURT, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 X Burial 2 Cremation 3 Removal from State EMINAH AITZ CEMETERY 4 Donation 5 Other (Specify) 11/29/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coloractal Carcinna Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death cartificate be exacuted physician and is the burial-trans resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 DOA this funarai Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No rdaath Director: A Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined fillad in within 24 hours a

To the Funeral C

compiataly fillad Medical eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa and title of certifier License number ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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Martez	Countess

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ledical Examiner Martez Miguel Countess Month Day Year November 26, 2012	3. Time of Death 1424 hrs	
dedical Examiner Martez Miguel Countess November 26, 2012	1424 nrs 1	
4a. Facility Name (if not institution, give street and number) Mercy Medical Center 4b. City, Town, or Location of Death Baltimore 4c. County of Death N / P		
Funeral Director 5. Social Security Number 216-94-6326 6. Sex 1. Months Days Hours Min. 5. Social Security Number 216-94-6326 1. Months Days Hours Min. 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. 6. Sex 1. Age (In yrs. last birthday) 2. Foreign Court		
Usual Residence of Decedent		
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits	
MD N/A 6914 Old Harford Rd. Baltimore 10f. Zip Code 10g. Citizen of What Coun	1 X Yes 2 No	
	5.A.	
11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americ White, etc.	an Indian, Black,	
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15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname)		
Tr. Father's Name (First, Middle, Last) ONK 18. Mother's Name (First, Middle, Maiden Surname)		
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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or crematory or other place)		
To be the place of		
21 Signal re of Funeral Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr. Funeral H 2140 N. Fulton Ave. Balto. MD	ome PA 21217	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line	Approximate Interval Between Onset and	
Medical Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of):	Death	
Sequentially list conditions, b		
fany, leading to immediate Cuse. Enter Underlying Cause Due to (or as a consequence of): Cuse (Disease or injury that initiated		
events resulting in death) Last Due to (or as a consequence of): d. ME UNPENDED AMENDED AMENDED AMENDED AMENDED 23a,27,28a-f,per me,g934 12-12-12 sm	V	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to		
Year an autopsy prior to co	topsy findings available	
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	ompletion of cause of	
The state of Death (Check only one) 25. Was case referred to medical examiner? 1	s 2 No	
So the search of	:	
The spiral of th		
27. Manner of Death 1 Natural 5 Pending Investigation 1 Nacident 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Subject assaulted		
24a. Was an autopsy performed? 1	ral Route Number, City ger Street	
and Sill O 29a Certifier		
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo		
O.C.M.E. OCME November 27, 20		
30. Name and address of person who completed calculated of death (Item 23a)		
Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		
State 31. Date filed (Month, Day, Year) 32. Registra's Signa dre Registrar 0 0 3 2012		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year PM Cook 27 2017 Christine Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nancy Mary Sam Nursing Home Washington <u>Hagerstown</u> Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 06-10-57 Months Hours 218-72-6537 Director MD 1 🗆 M 2 🖾 F 55 Usual Residence of Decedent 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XXNo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 14014 Marsh Pike USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. African 1X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify Specify: American "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never worked Never worked 12th Grade NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည S. Mary Cook Ray Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doretha McFadden-Sister 320 N. Calhoune Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place Trinity Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 12-03-12 Dundalk, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Furier I Service J. Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Injerval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-tran resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnincy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 🗌 Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 1KG မှ 1 🗆 Yes 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifler 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29d. Date signed (Month, Day, Year) 29c. License numbe 128 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OVEMBER 24, 2012 4c. County of Death В. Chapman /Medical Fdward 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hr Months Days Hours Mir Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 03–16–20 Social Security Number . Age (In yrs. last birthday) Funeral 1 💢 M 2 🗆 F Months Days 048-01-9800 92 **Director** MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 2413 LLewellyn Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🛛 No ρ If Yes, Give Specify. Specify: 3 Divorced 4 Divorced American Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arab Horse Courier 6th Grade NĂ Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doss John Chapman Carrie Department of Health and Men Important: If Item 27 Is marked any injury or other traumatic ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 N. Broadway Baltimore, Maryland 21205 19a. Informant's Name/Relationship (Type. Print) Lorraine Chapman-Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 12-10-12 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each rin. Approximate nterval Between paset and Death Immediate Cause (Final **Physician** orona resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine signed by the attending physician and if be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) I∐Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform death? 1 ☐ Yes 2 7 2 12 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 FNOutpatient 3 DOA After this Certification: To funeral 27. Manno of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29c. License number D0066588 29b. Signature and Grember 24,2012 30. Name and add who completed cause of death (Item 23a) (Type, Print) 900 S Coton Are Buttime MD 21229 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date fled (Month

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** EVEN CRIS 604 M 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, YO) 3-03-73 Birthplace (State or Foreign Country) **Funeral** Min 1 XM 2 ☐ F Months Days Hours 441-72-3472 39 Director OK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exp. time in 181 by notified at once. Director MD NA YE Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3820 Boarman Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: American ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore 11th Grade NA Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Crisp Geraldine Benjamin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Crisp-Mother 3820 Boarman Avenue Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 12-07-12 Lansdowne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death orications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** Myoren disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) November 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:35PMM Medical ELEANOR LOUISE CRAWMER December 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 213-24-8324 Director 1 M 2 X F 32 Nov. 9, 1930 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1209 Old Manchester Rd. 21157 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Completed Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 seamstress Clothing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George H. Stouffer Mary Gonder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Crawmer/husband 1209 Old Manchester Rd. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem. 12/5/12 Westminster, MD signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ ment disease or condition resulting in death) PUS Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this northing eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes []/No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 12 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILAUI 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. #25, 27, 28A-F, PER ME G933 11/29/12 TRT State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 10.20 a Helen Mae Cavey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital et Easton Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) 220-18-7535 85 Director 1 M 2 F Yrs 7-7-1927 MD Usual Residence of Decedent permit. Pege 1 and 2 should be flied within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any Injury or other treumetic event, the Marcel Exercitivate ust be method at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Talbot Easton MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9285 Honeysuckle Dr. 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specifiwhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Franklin Sisk Mary Triplett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll M. Cavey-husband 9285 Honeysuckle Dr., Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎦 Cremation 3 ☐ Removal from State Central MD Crem 11/13/12 Westminster, mD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation nomas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) pulmonan embolism 10 minutes Medical Due to (or as a consequence of) Examiner tractune 2hars Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Examine (fic enneupsence is a rc) of elic EXAMINER be detached for use es the burlal-transi To the Hospitel or Attending Physicien: The law requires that the death certificete be executed ON APPROVED BY MED signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funerel Director: After this certificate has been sly completely filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending SUBJECT FELL 2^XE No 1 🗌 Yes Investigation /10/2012 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 9 2 8 5 HONEYSUCKLE DR EASTON, MD determined HOME Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Fisher atthew /iz //2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Multhur Tischer MD ZMertin (31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylan	_	artment <i>tificat</i> e			and M	lental Hy	gien Reg. N	20	12	388	320
	Physicia	n/	1. Decedent's Nam			-						2. Date of Death November Day 25 2012 9:17 PM					
-	Medic	al_	4a. Facility Name (if	Seasong				4b. City, Town, or Location of Death				4c. County of De				9:17	₽м
9)	CI	Frederi	ick Memo			al	Frederick				Frede			ck		
	Funeral Director		5. Social Security N 254-76-38		Sex 1 X M 2 □ F	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi			9. Birthpl Count	ace (State or	Foreign
			Usual Residence	of Decedent	TAJWIZ LIF	51	Yrs.					10/04/	196	1	Geo	rgia	
	ryland I-f sho	ctor	10a. State	10b. County			y, Town or Lo								10	0d. Inside Cit	
	he Ma or 28a	Dire	MD 10e. Street and Nur	Freder	ICK	Fr	ederic	10f. Zip (Code	-			10a. (Citizen of V	What Count		2 🖭 NO
	s 23e	Funeral Director	6097 For	untain D	rive			21	702					.S.A.		,	
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Maryland 21215-0036	rs after rrel", o Exam	ed by	3 Widowed		1 X Yes If Yes, Give Year or Da	•		☐ Yes 2	X No	Specify:				Specify:	Whit	e	
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Records,	aw require as been si 2 should I	plet										24a. Was		24b. \	Were autop	sy findings a	vailable
	sician: The law is certificete has be lirector, page 2 s		25.11		<u> </u>								ormed?		death? 1 🗌 Yes	•	
233 Vital	ysician: is certific director,	To Be	25. Was case referrex examiner? 1 🔀 Yes 2		Hospital:	npatient 2 🔀	FR/Outpatier	# 3 DO	Otho	r:	'	only one) ne 5 ☐ Resi	idanaa	€ [] Oth	or (Canaibi)		
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Division	uttendi death. ctor: A cy the f	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investigation 6 Could not	be ORa Diago	of Injury - At ho	ome farm stre	M eet factory		Yes 2 🗆	\rightarrow	28f. Location (Stract	and Numbe	or or Duml I	Pouto Numb	25
DIV	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		4 🗌 Homicide	determine		g, etc. (Specify		out, idolory,				City or To			er or nurari		-i,
	Hosp 24 hou Funel etely fi	Medical	(Check 2	Certifying Ph Medical Exar	niner: On the basi	s of examination	n and/or invest	igation, in my	y opinior	n, death oc	curred at	the time, date	and plac	ce, and due	e to the caus	se(s) and mar	ner stated.
	To the I within 2 To the I comple	2	29b. Signature and		Se i lacutoller.	TO the best of h	ny kilowicago,	29c. l	License	number	e and plac	se, and due to			(Month, D		
			> "/	yfin	m a	2		1	101	5161	٥		11	1/28	112		
(10)			30. Name and addr	ess of person who	n .	of death (Item	23a) (Type, F	rint)	على	rich	i V	ND	.7	17	cif		
1)	Sta		31. Date filed (Mont	th, Day, Year)	32 Re	egistrar's Signat	ny knowledge,										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph Conway	1- For State Registrar	ate of Maryland /		nt of Health te of Death	and Mental F		g. No. 20	12 3882		
Physician/ ledical Examine	Decedent's Name (First, Midd	le,Last)	Joseph	Renard Co	nway III	2. Date of Death Month November		3. Time of Death 2114 hrs		
	4a. Facility Name (if not institution			4b. City, Tow	n, or Location of Dea		4c. County of D			
~ /	Saint Agnes Hospital	[0.0x	/I I b. i.ub	Baltimor		lo Data d'Bist	(District (Otat		
Funeral Director	5. Social Security Number 218-25-8793	6. Sex 7. Age	(In yrs. last birth		Year If Under 24H Days Hours M	-		Birthplace (State or preign Country) MARYLand		
any	Usual Residence of Decedent 10a. State 10b. County		0c. City, Town o	r Location				10d. Inside City Limits		
A ."	md		Bal	Himore	2			1 Yes 2 No		
th the Maryland 23s or 28s-f sho notified at once.	10e. Street and Number	, ,	_	10f. Zip Co		10	g. Citizen of What (_		
ith the 23a o	28 26 Gan	12. Was Decedent E			230 of Hispanic Origin?	Specify Yes or No-	U.S.	merican Indian, Black,		
r death with or items 22 must be no	1 Never Married 2 N	arried Armed Forces?_	No		as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)			c.		
ral", o		rorced If Yes, Give Year or Dates:		1 Yes 2				Black		
2 hours. "natur: Exami	15. Decedent's Education (Spe Elementary/Secondary (0-12)	city only highest grade comp College (1-4 or 5+	di	uring most of working	cupation (Give kind or g life. DO NOT use re		16b. Kind of Busine			
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	12			odel	2065		Labo	R		
	17. Father's Name (First, Middle	, Last)				ne (First, Middle, M	laiden Surname)	\sim		
2121; ould be fill d Mental F s marked lic event, To Be	19a. Informant's Name/Relations	thip (Type, Print)	2 19b.	Mailing Address (Street an Number of	r Rural Route Numi	ber, City or Town, S	itate, Zip Code)		
MD d 2 sh lth an n 27 i	goland Sm	ith	2	-826 GA	inley Di	eive Be	alto, mo	0. 21230 y or Town, State		
Baltimore, Nemit. Pages I and Department of Health Important: If item injury or other trau	20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from State	20b. Place of cremator	Disposition (Name or ry or other place)	of cemetery,	Date 2/12	20c. Location - Cit	y or Town, State		
	4 Donation 5 Other S 21. Anature of Funeral Service		MY	22 Name and Add	tress of Broility	1605 00	150LH	· Maria		
Balti permit. Departit Importi	Geoffun/	heller		3109 E.	RdMAN	Are. B	046. Me	o. M.C.		
Physician	23a. Part I Enter the disease, or failure. List only one cause	complications that caused the on each line.	ne death. Do not	enter the mode of d	ying, such as cardiac	or respiratory arre	st, shock, or heart	Between Onset and		
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Methadone Due to (or as a conseq		ation				Death		
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M B FE EX	(Disease or injury that initiated events resulting in death) Last									
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760, cate be physici he bun	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of del	ivery		
Box 68760, e death certificate be the attending physical for use as the burn hysician/Med	23b. Was decedent pregnant in t past 12 months?	1 Live birth 1 Pregnant at ti	me of death 5	Fetal death Other (Specify)	3 Ectopic preg	nancy	Month	Day Year		
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the buricompleted by Physician/Med	1 Yes 2 No 9 Un	known g Unknown								
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ords, P.C w requires that as been signed 1 should be deta						24a. Was a	n 24b. Wer	e autopsy findings available		
Records, The law requires ficate has been sig , page 2 should be Completed						autops perform	med? deat			
				26.8	Place of Death (Chec		NO I	Yes 2 No		
of Vital g Physician: frer this certif neral director,	1 ✓ Yes 2 No		t 2 ER/Out					Other;		
on of adding Ph. : After te funeral	27. Manner of Death 1 Natural 5 Pen	28a. Date of Injury (Month, Day,Yea	ar)		Injury at Work? Yes 2 🗶 No	unknowi	ow injury occurred			
r Atter r Atter ter dear irector n by th	2 Accident Inve	stigation 28e. Place of Inju	ıry - At home, far	m, street, factory, of	fice building, etc.	28f. Location (S	treet and Number of	r Rural Route Number, City		
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	(Check only 1 Certifying P	hysiclan: To the best of my miner:On the basis of exami	_							
Se se se se se se se se se se se se se se	29b. Signature and title of certifi	and manner stated. er		29c. Li	cense number		29d. Date signed	(Month, Day, Year)		
	hing h	~		C	C.M.E.		November 28	, 2012		
0	30. Name and address of person Ling Li, MD Assista	who completed cause of deant Medical Examiner		Iltimore Street,	Baltimore, MD 2	21223				
State	31. Date filed (Month, Day, Year)		s Signature							
Registra	DEC 0 3 2012	Jener B.	park	CINAL		n n	OME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann Dora Cantor 0410 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 220-14-9462 Director 1 □ M 2 💢 F 89 10/03/1923 Maryland 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
I tem 27 is merked other then "natural", or items 23a or 28a-f ahow other traumatic event, if e Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3124 Gracefield Road, KC #223 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 🗌 Widowed 4 🗋 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Leavey Essie Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If Item 27 Is any Injury or other trau Robert G. Cantor - Spouse 3124 Gracefield Rd, KC223, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lebanon Cemetery 12/03/2012 Adelphi. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
3 Years Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimer's Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transil that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hospitel or Attending Physicien: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 ☐ Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Director: / Investigation To the Hospitel or Atter within 24 hours after ded To the Funerel Director completely filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D24093 November 30, 2012 Ju 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, Maryland 20904 Mark Parkhurst, M.D., 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38823 Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ene Davis 2017 Medical 672K 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 1731 Sykesville Rd. Sykesville If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 018-20-4158 **Director** 1 □ M 2 🛣 F 01/14/1926 86 Ma. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Howard Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1731 Sykesville Rd. 21784 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 □ Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12vrs Housewife Homemaker any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မ Howard Smith Harriett Carolyn Langille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Davis(Son) 2212 Rockwell Ave Catonsville, Md. 21228. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😿 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Crest Lawn 12/08/2012 Marriottesville, Md. 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel 195 Sykesville, Md. 21784. Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ recest disease or condition resulting in death) grant Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and d for use as the burlal-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signe, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 HNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one vilv 29b. Signatul and tithe 00053337 mber 1 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doro State Registrar

6934 HVIAtion 31. Date filed (Month, Day, Year) 3

Boulevard

Burnie, Moziolei

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38824 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 135 a M ownbe J. Davis Theresa Medical 4a. Facility Name (if not institution. give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death timore NA If Under 1 8. Date of Birth 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Min 099-40-8433 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA 1 X Yes 2 □ No Baltimore 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be 23a Funeral Caroline Street Apt.#3-F 21213 items 2 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 9 þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☐xNo Specify: "natural", Completed 3 Widowed 4 Divorced American 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade <u>Geriatric Nursing Assistant</u> Future Care N.H NA and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Davis Gloria Daves permit. Page 1 and 2 should I Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 2808 Clifton Park Terrance Baltimore, Maryland 21213 Aaron Davis-Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State Randallstown, MD 12/03/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. any i 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or compolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of). requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has page 2 performed? Yes 2 No death? Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home \(5 \sum_{\text{Residence}}\) Residence \(6 \sum_{\text{O}}\) Other (Specify, 2 No 1 🗌 Yes ၉ 1 M Inpatient 2 - ER/Outpatient 3 - DOA this 27. Manyler of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner-On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D006 NOV 201) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) BALTIMORE MD 2120 Shavm a 821 N. FUTAW ST. SUITE 301 al

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month THEDA AILEEN DAYHOFF December 8:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizen's Nursing Home Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country Director 215-14-1946 1 M 2 X F 90 1922 June 27, Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumetic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21702 <u>6792 Sunnybrook Drive</u> 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Oden Warner Bessie Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Hoff/sister 6792 Sunnybrook Dr. Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) County Cremation Svkesville, MD Signafus of Funeral Service Coensee 22. Name and Address of Facility Hartzler Funeral Home 310 Church St New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final HETASTATIC CANCER Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter II, certying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami igned by the attending physician and be detached for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only-ene 29b. Signature ar 20062223

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYEEN BOCAMM, 196 TIMUE, PRINCE, MI 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 30, 2012 Year Manuel Doliveira, Jr. 4:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Baltimore Gilchrist Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 83 117-18-1764 Director 1 XXM 2 □ F 3/14/1929 Pennsylvania 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Phoenix 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21131 U.S.A. 2617 Stockton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black. White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If You Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Black & Decker Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mantal F 7 is marked of ည Anna Mosley Manuel Doliveira, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a Item 27 is 2617 Stockton Road Phoenix, Maryland 21131 Maria Doliveira / wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Paga 1 s
Derartment of H
Importent: if ite
any injury or ot Date cemetery, crematory or other place)
Dulaney Valley Mem. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/4/2012 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, maryland 21204 23a. Part 1. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, il any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month signed by the a Id be detachad f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? cartificata Physicien: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ Aftar this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o the Moepital or Attending Phyeithin 24 hours after death.

the Funeral Director: After this omplately filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) D71040 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Quite 4105 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 28, 2012 Physician/ **Ellsworth** Demarest, Jr. Harry 8:15 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1906 Glen Ridge Road Parkville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Days Hours Director 1 😾 M 2 🗆 F 90 144-16-6164 1922 Jan 2, New Jersey Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1906 Glen Ridge Road 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 40-145 1 ☐ Yes 2 √ No Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Insurance Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Demarest, Sr. Isabel Martin Howell Ellsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 1906 Glen Ridge Road, Parkville, MD 21234 Eleanor C. Demarest-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
eny injury or o 1 X Burial 2 Cremation 3 Removal from State MD Vet, 12/12/12 Owings Mills, MD Garrison For. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau Towson, MD 1050 York Rd.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ FIBRILLATION ATRIAL Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last CHRONIC FNSUFFICIENCY Due to (or as a consequence of) Physician/Medical DIABETES 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetai dea 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) signed by the el d be detached f Yes 2 No 9 Unknown Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SABA State Registrar

29b. Signature and title of certifie

7505 OSLER DRIVE Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 0058656

29d. Date signed (Month, Day, Year)

NOVEMBERL

touson,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM# 20b, perFH, G934, 12/6/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 0 Physician/ NOV Medical Examiner 4b City, Town, or Location of Death 4c. County of Death Baltimore @ NW KANdAllstown Hospice If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 120-48-2662 56 Yrs. **Director** 1 □ M 2 🛛 F , NY QUEENS 16 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumetic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director BAHO 1 Yes 2 No IND Owings Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1709 Dark Star USA 2111 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 \square Never Married 2 \square Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
BAITO City (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) condary (0-12) pecial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Burre 11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ferguson ArIton SON toxhound KANDAllstown, MD 21133 Baltimore, 20b. Place of Disposition (Name of Negretary, crematory or other place) 20a. Method of Disposition Date UNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Port Washington. Park 12/7/2012, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGhN 21. Signature of Funeral Service Licenfee C. GREENE Liberty Rd, Randall 8128 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 🗌 Yes 2 🕡 No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide 2 🗀 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State 3 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8130 am Robert M. Flint Jr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 14 Dutton Avenue Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) Director 350-30-4412 1 X M 2 - F 72 Yrs 1940 Jan 24, Usual Residence of Decedent <u>Illinois</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Dutton Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 1 No Specify. white Specify: 3 Divorced 4 Divorced Year or Dates. 163-68 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ administrative Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert M. Flint Sr Hazel Rose Lorimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Flint/spouse 14 Dutton Avenue Catonsville, MD 8:304m Baltimore, N 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Emeral Service Livenses 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimere, MD 21201 3a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): After this certificate has been signed by the ettending physician and funeral director, page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last expired Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Rober 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 21 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

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Registrar

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31. Date filed (Month, Day, Year)

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JUNEBUL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Robert Owen Gooby 10:00AM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3912 Regency Parkway #105 Suitland, PG 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 188-30-4629 Director 1 3x M 2 □ F 75 04 04 1937 Easten, MD er then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits by Funeral Director PG Suitland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3912 Regency Parkway 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Maryland 21215-0036 _{sp}B.l.ack 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Construction of Health and Mental Hygie If item 27 is marked other in other traumatic event, <u>tr</u> Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rafiah Gooby - daughter if item 27 3904 Regency Pkwy #203 Suitland, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Department Importent: If any injury or Chesapeake 4 Donation 5 Other (Specify) 11/21/12 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Gervice Licen Freeman Funeral Service 4594 Beech Rd Temple Hill, Md 20748 23a. Part 1 Enter the disease, or compline shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Pnysician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by the at d be detached for g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Cardiomyopathy Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2 🗎 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🖾 Residence 6 C Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jocelyne 163740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne T Koutchou 210 E. University Pwky. Baltimore,MD 21218 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

MDHMH 17 Rev 06-2011

12-08599	
Stephen Gunnell	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar Certificate of Death Reg. No.
. Hyororani	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
Medical Examiner	Stephen Gunnell November 12, 2012 2100 nrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	13101 Clifton Road Silver Spring Montgomery
Funeral	5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Unik
Director	1 M 2 F 64 Yrs. World S Days Hours Will. Feb 22, 1948 Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	MD Montgomery Silver Spring 1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
3 or Sa or	13101 Clifton Road 20904 USA
or items 23a or 28a-f sho must be notified at once. Funeral Director	11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	1 Yes 2 No UTIX 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: White
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by I	To Dates:
0 = 2	Elementary/Secondary (0-12) College (1-4 or 5+)
-0036 I within 72 giene. her than " her dian "	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk
2121 hould be find Mental is marked ritic event, To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore Street Baltimore, MD 21223
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: U item 27 is 1 other traumatic	O.C.M.E. 900 W. Baltimore Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Ore ges 1 a tof He ither t	1 Burial 2 Cremation 3 Removal from State crematory or other place)
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other to injury	4 Donation 5 X Other Specify: in state 21. Signature of Europe at Service Appendix 6 22. Name and Address of Facility
Dep Dep	Ronald W. Made, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
:xaminer	Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Due to (or as a consequence of):
	Sequentially list conditions, b
iner	if any, leading to immediate Due to (or as a consequence of):
led Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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760, cate be exect physician an he burial - tr	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
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by the attending inched for use as t	1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown
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ords aw req as beer as beer s shoul	24a. Was an autopsy findings available autopsy prior to completion of cause of performed?
tal Reccian: The Lecrificate Pector, page	1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital ysician: ysician: his certi director	25. Was case referred to medical examiner?
of Vi ing Physi After this uneral dir in: To	27. Marcos of Death 28. Data of Jajury 29h Time of Jajury 29h Lings of Jajury 29h Death 29h Deat
ion itendii leath. tor: A	1 X Natural 5 Pending 2 Accident Investigation
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Exidenced Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
D To the Hospital within 24 hours To the Funeral Completely filled	
To the Ho within 24 To the Fu completel	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F 3 F S	10
	(alumental O.C.M.E. November 13, 2012
	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registra	WELL CONTRACTOR OF THE PROPERTY OF THE PROPERT
DHMH 17 Rev 1/2001	ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Betty Lou Grover 3:30 NOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 217-36-7789 Director 1 M 2 X F 71 Dec 13. 1940 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director MD Queen Annes Queen Anne 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Owens Road 21657 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🕅 No 1 ☐ Yes 2 X No Specify: Yes. Give Specify: white Completed 3 to Widowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, Maryland 21 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gray Hilda Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEbra Bargerstock/daughter 409 Ownes Road Queen Anne, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signature of Freezel Service Littensee Rona Td 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director; After this certifics letely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗀 No Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) em 23a) (Type, Print) LurlesS 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 25, PER ME, G933 11/29/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 10, 2012 Physician/ 11:10 ам William F. Horner, III Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Maryland Masonic Home Cockeysville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours (Month, Day, Year) 1 🖳 M 2 🗆 F 193-24-6304 79 Director Pennsylvania April 20 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Harford Baldwin 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3103 Morningside Court 21013 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 55**-'**58 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. Geraldine Sorber William Horner, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Morningside Ct., Baldwin, MD 21013 Bonnie Lee Lloyd-sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv Corp 11/13/12 Towson, MD 21. Signature of Funeral Savice Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Stage Immediate Cause (Final Physician/ disease or condition resulting in death) . Medical Due to (or as a consequence of) Examiner AR kin sm's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of), FXAMINER Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Delinstus, CAD 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 110 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3508 RUBENT 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH G943 12/06/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Heiderman, Jr. 201^{Yea} Walter December 10:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9524 Gunhill Circle Nottingham Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year) Aug 2, 1924 Maryland 217-18-6494 Director 88 1 XM 2 | F Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 9524 Gunhill Cirlce U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Black White etc. Completed by 1 Never Married 2 X Married 2 -XNo XXes Baltimore, Maryland 21215-0036 Give 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness/Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Went: Important: If item 27 is marked any injury or other. Elizabeth Walter H. Heiderman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9524 Gunhill Circle, Nottingham, MD <u>Edith A. Heiderman-wife</u> 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 12/6/12 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Timonium, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. towson, MD 21204 1050 York Rd.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician ementia disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the attending physician and ched for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? page 2 should be detached for Month Day Vear 1 ☐ Yes 2 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending work' 1 \square Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Towson MD 21204 Jason Black 701 Worth 31. Date filed (Month Day, Year)-State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Year Richee Tyra Holmes November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Union Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 212-29-5368 Director 24 1 □ M 2🗓 F Yrs 10/08/1988 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2635 Barclay Street 21218 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Completed by should be filed within 72 hours after and Mental Hygiene. Maryland 21215-0036 1 ☐ Yes 2 Ž No Specify: Specify: Black 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Day Care Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Tyrone Holmes Cynthia Renee Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 548 E.38th Street Baltimore, Maryland 21218 Cynthia Brooks Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Memorial Park 12/01/12 Windsor Mill, MD. 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Thrombotic thromboutopenic 40 days Medical resulting in death) Due to (or as a consequence of) Examiner 37 days Lupus nephriti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 24 days the Hospital or Attending Physician: The law requires that the death certificate be executed Intra Cranial Hemorrha attending physician and I for use as the burial-trans Due to (or as a consequence of): 43 days Physician/Medical stemic Lupus erythematosus Flare Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 Unknown been signed by the a should be detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should t Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After I filled in by the funer Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation
6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) hours Funeral Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 (Check 3 L Gertifying Norse Practitioner To the best of my knowledge, de consumed at the time, date and plane, and due to 29b. Signature and title of certifie M.D. (Pirasulfu AT2438946 _I 13 November/20/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hrastehfar Vaion Memorial Hospital 201 E. University Parkways Baltimore, MD 21218 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year/2 Hinkel Day / 3 Physician/ Month // Dorothy 9:46 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Parkville Baltimore Oakcrest Village 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 219-28-3908 1 □ M 2 🗓 F 80 Nov 9, 1932 Maryland permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Dapartment of Heelih end Mentel ingliene. Important: If item 27 is marked other than "natura", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd #3519 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 loan officer credit union Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Loretta Shanahan Theodore Herbert Hohenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6437 Cloister GAte Drive Baltimore, MD 21212 Stephen R. Hinkel/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Ronal State Anatomy Board 655 W. Baltimore Street S de, Director 21201 Baltimore, MĎ 23a. Part . Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hoepital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be dateched for use as the buriel-trensit rulmonary that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N Vital 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KR Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0052365 11-16-2012

Registrar

State

5

Walther Boulevard Parkville MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

32. Registrar's Signature

Jeffreys

0 3 2012

31. Date filed (Month, Day, Year)

12-08685 Katie Hollins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

lie Hollins		State of Maryland / Department 1- For State Certificate Registrar		Reg. No. 20	2 3883
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) Katie Hollins		2. Date of Death Month Day Year November 15, 2012	3. Time of Death 1923 hrs
		4a. Facility Name (if not institution, give street and number) 3844 Elmley Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Dea	ith /A
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (MM/DD/YYYY) 9. E	irthplace (State or
Director		UNK 1 M 2 ★ 82 Usual Residence of Decedent	Yrs. Months Days Hours Min		Country) NC
ow any		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 X Yes 2 No
vith the Maryland s 23a or 28a-f show a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?
vith the last s 23a or e notified		3844 Elmley Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21213 Was Decedent of Hispanic Origin? (Si	U.S.A	A . erican Indian, Black,
r death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
ours afte	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	Yes 2 X No specify: dent's Usual Occupation (Give kind of v g most of working life. DO NOT use reti		
736 thin 72 hc ne. than "nu fedical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	sekeeper	Own Hor	me
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Higtene. 27 is marked ather than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Be Cor	17. Father's Name (First, Middle, Last) UNK		e (First, Middle, Maiden Surname)	
VD 212 2 should be the and Ment 27 is mark	To E		illing Address (Street and Number or I	Rural Route Number, City or Town, Sta Baltimore, MD	
구 당등 목 등		20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery,	Date 20c. Location - City	
Baltimore, permit. Pages i at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: On-Site	e Crematory d	I/ID Baltimor	•
		Dietrop N. William	2140 N. Fulton	n, Jr. Funeral Ave. Balto., I	MD 21217
Physician /Medical xaminer		Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line. Immediate Cause (Final disease		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Xammer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	Examiner	frany, leading to immediate Due to (or as a consequence of): Cause Clisease or injury that initiated C.			
uted nd ransit		events resulting in death) Last Due to (or as a consequence of): d.			
60, ate be executed hysician and e burial - transit	Medical	UNPENDED AMENDED			
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Live birth 2 Pregnant at time of death	Fetal death 3 Ectopic pregna	23d. Date of deliver	ery Day Year
BOX he death y the atte	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	Other (Specify)	23e. Did tobacco use contribute	the second field
ires that the signed by	ē	Asthma, chronic obstructive pulmonary disease, Parkinso	, ,	1 Yes 2 No 3 Pr	
of Vital Records, og Physician: The law require. The the requirement of the control of the contr	Completed				autopsy findings available completion of cause of
		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No 1	Yes 2 No
of Vital ing Physician: After this certif uneral director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		ng Home 5 Residence 6 🗹 Oth	er; Scene
		27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Division tal or Attendi rs after death. al Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, so (Specify)	street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
Hnspi 24 hou Funer stely fil		29a Certiffer 1 Certifying Physician: To the best of my knowledge, death or (Check only)			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or invested end manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (M	
		allell (O.C.M.E.	November 16, 2	
		30. Name and address of person who completed cause of eath (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W	/. Baltimore Street, Baltimore,	, MD 21223	
St	ate trar	31. Date filed (Month, Day, Year) 37 Registrar's Signature	while		- N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5, per fh, 2934, 12-3-12 sm.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOLDREA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VONTHWE 2 m 5. Social Security Number 214-326-7062 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 1 🗆 M 2 💢 F Washington, D.C. 1-04-1917 23a or 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Kandallstown Mary kind Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 United States Horse man 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b, Kind of Business/Industry City Himare Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools eacher should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or according to the property of the property or according to the property of the property or according to the property of the property or according to the property of the property or according to the property of t 2 Albert Sytten Samie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Argentine Logac Dang 4to Horseman Cont Randalistown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Metro Dec. 4, 2012 MD Buttonoras 4 ☐ Donation 5 ☐ Other (Specify) remetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LLVIN WILLIAMS FS, alvin Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANTERIOSELEROTIC CHRONOVAS Cuta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence on sician and burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) fo in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 WHO 9 Unknown signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOMYOPATHY To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 W Unknown page 2 should adaGulopatety 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed After this certificate DiD CEREBROVASCULA 2 10 No Yes 2 No 1 Yes the funeral director, Be 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 🗌 Yes မ 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No after death. Director: Aft 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - HOSPITAL CHANA ORCANOC

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Weenber 29 hnson Medical Facility Name (if not institution, give street and n 4b. City, Town, or Location of Death **Examiner** 4c. County of Death rakyland Greneral Itimore last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🔽 F **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ✓ Yes 2 ☐ No timore 10e. Street and Number 10f. Zip Code Apt. 10g. Citizen of What Country? Funeral USA Tark "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced lac Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most life, DO NOT user stred) 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than " any injury or other traumatic event, the Me once, College (1-4 or 5+) Elementary/Seconday (0-12) vocate for veurs Be Baltimore, Maryland ather's Name (First, Middle, Last) ည Moorman nformant's Name/Relationship TVI (Pratughter) Method of Disposition 20b Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Entertite disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one person on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ DIROCTORY arlure disease or condition Medical resulting in death) (or as a conse Examiner neumona ione/la Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine on Small (e Carcinoma To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death page 2 should be detached Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jayenell Ebony Jackson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Jayenell Ebony Jackson November 24, 2012 0341 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country) Months Days 216-43-0161 Hours Director 12/23/1994 MD 1 M 2 XF 17 Yrs Usual Residence of Decedent Any 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show N/A 1 Yes 2 No MD Baltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2537 Ashton Street 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 2 X No Yes, Give Year 3 Widowed 4 Divorced Yes 2 X No specify: Specify: Black ੬ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 t. Pages I and 2 should be filed within trment of Health and Mental Hygiene. Student N/A 10th 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) æ John Stanley Jackson Robin Jaye Toland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Jaye Stewart (Mthr.) 2537 Ashton St. Baltimore, MD 21223 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 XCremation 3 Removal from State Baltimore, MD On-Site Crematory Donation 5 Other Specify: 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Town Jr. Funeral Home PA 2140 N. Fulton Ave. Balto., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical the attending physician led for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of Yes 2 No 2 No 1 🗸 Yes Hospital or Atteoding Physiciao: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 After 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification Nov 24, 2012 Subject passenger of motor vehicle in motor 1 Natural 0210 hrs oeral Director: 1 Yes 2 ✔ No Pending vehicle accident 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 95 N @ 76.5 Mile Marker, Joppa, Md determined (Specify) Interstate/Express Fuoeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. 00ME November 25, 2012 30. Name and address of person who completed pause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

remaine Johns		1- For State Registrar	Ce	rtificate of Dea		id Meritai r		eg. No. 2012	38842
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Middle, Las Tremaine Johns	*				2. Date of Dea Month Novembe		3. Time of Death 2153 hrs
•		4a. Facility Name (if not institution, given University Hospital	ve street and number)		, Town, or imore	r Location of Deat		4c. County of Death N/A	
Funeral Director			ex 7. Age (In yrs. 3 4	last birthday) If Ur Mor Yrs.	ths Day			th (MM/DD/YYYY) 9. Bird 7 / 78 Foreig Coi	hplace (State or n_MD untry)
and show any occ.	٦	Usual Residence of Decedent 10a. State	10c. City Ba.	Town or Location ltimore		_			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a nr 28a-f shn notified at once.	Director	10e. Street and Number 1201 N. Chapel	st.	10f. 2	2121	13	1	0g. Citizen of What Cour USA	itry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a nr 28a-f shu injury ur other traumatic event, the Medical Examiner must be notified at once.	by Funeral	_	1 Yes 2 No	If Yes, spe	cify Cuba 2 🔀 No	spanic Origin? (S n, Mexican, Puert o s <i>pecify:</i>	o Rican, etc.)	White, etc. Africa SpecifyAmer	•
1036 Aithin 72 hours ene. er tran "natur Medical Exam	mpleted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	_		e. DO NOT use re		16b. Kind of Business/I Construct	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last Maurice Johns				Diane	Malloy	Maiden Surname)	
MD 21 d 2 should Ith and Me n 27 is ma	70	19a. Informant's Name/Relationship (*Lisa Houston	Type, Print)	19b. Mailing Addre	ss (Stre Lai	et and Number or nvale S	Rural Route Nur t., Bal	nber, City or Town, State t . , MD 212	
Baltimore, bermit. Pages I am Department of Heal Important: If Iten		20a. Method of Disposition 1	Removal from State	Place of Disposition (Note: Pl	emat	ory 12	Date :/5/12	20c. Location - City or Balt., MD	
Bal permi Depar Impo		21. Signature of Funeral Service Lice						lose F.Svs MD 21206-	5105
Physician Medical		23a. Part I. Enter the disease, or comparitive. List only one cause on elementation of the comparities of			e of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a consequence of						
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
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OX 687 eath certific attending p	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at time of do	2 Fetal dea		Ectopic pregr	nancy	Month E	ay Year
P.O. Es that the d	ব্র	Part II. Other significant conditions	contributing to death but not	resulting in the underly	ng cause	given in Part I.		obacco use contribute to s 2 ✓ No 3 Prot	
of Vital Records, P.O. ng Physician: The law requires that it Nfer this certificate has been signed by meral director, page 2 should be detach	Completed						24a. Was autor	an 24b. Were au	topsy findings available ompletion of cause of
Vital Recc ysician: The lav his certificate ha		25. Was case referred to medical			26 Plac	e of Death (Chec	1 🗸 Yes	rmed? death? 2 No 1 ✔ Ye	s 2 No
Vita hysician this cer	To Be		Hospital: 1 🗹 Inpatient 2	ER/Outpatient 3	DOA	Other -	ing Home 5	Residence 6 Other	:
on of vending Phrasth. or: After ti		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury FOUND: Nov 25, 2012	28b. Time of Injury FOUND: 2140 hrs		ury at Work? Yes 2 ✔ No	28d. Describe Subject sho	how injury occurred ot	
Division ital or Attendii rul Barer death	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury - At h		ory, office	building, etc.		Street and Number or Ru State) Ihoun Street, Baltimor	
Division To the Huspital or Attency within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only 1 Certifying Physic	clan: To the best of my knowled r:On the basis of examination a and manner stated.						
F 3 F 3	¥	29b. Signature and title of certifier	1 mx			se number		29d. Date signed (Mo. November 26, 20	
3~		30. Name and address of person who							
S S	tate	31. Date filed (Month, Day Year)	ssistant Medical Exami		imore s	Street, Baltim	ore, MD 212	23	
Regis	_	DEC 0 3 2012	Zenoa B. A	ale					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Odessa Johnson November 2012 6:44 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Hours Min. Director 214-24-4449 1 □ M 2 🗓 F 85 Dec 7, 1926 Maryland Usual Residence of Deceder 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medicel Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Randallstown 1 ☐ Yes 2 ▼ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5109 Old Court Road #222 21133 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black If Yes, Give 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 healthcare 11 nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Sidney White Ethel May Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau Annie Johnson/friend <u>706 Augusta Avenue Baltimore</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approximate 21. Signature of Funeral Service ROna Loc Wirector 6 1 23a. Pp. 1. Enter the disease, * complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shr ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (c a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death.
the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 06-2011

State

nd title

Name and address of person who completed cause of death (Item 23a) (Type, Print)

houles S

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #11,16a&b, 18&22 Per FH G934 12707/2012 JH State of Maryland / Department of Health and Mental Hygiene #19a&b 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** PM 50 0/3 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not in stitution, give street and number) Examiner BATIMONE HOIDITAL BA/TI 1612 UIN LE LOSI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 U11 K 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 💢 F Months Yrs Director 212-94-6728 Sept 14. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other treumatic event, the Medical Examiner must be notified at MD Baltimore 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 818 Baker Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, importent: If item 27 is marked other than "natural", or items 23e any injury or other treumatic event, the Medical Examined ONDE. 21217 USA Funeral unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Xever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) MVA Customer Service unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk 1117 k Be Gloria Jefferson 2 19a. In Grant 1 am Jeff Person Mother 19b. M9 Ing Admini Steel and Durwin or RDal Owl Higher Mill I Term MB to Zi fire Bon Secours Hospital Baltimore Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 12/02/2012 Bayview Crematory Baltimore, MD * 4 □Donation 5 1 Other (Specify) in state 22. Name and Address of Facility Hari P. Close Fun. Service PA 21. Signature of Funeral S rvi de Board 655 W. Baltimore Street 21201 21206 5126 Belair RD Director 222 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEUNONIA 40 1000 disease or condition resulting in death) /Medical Due to (or as a consequenca of): Examiner Lirthes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit FROM LETCHING Due to (or a a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 4 No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director examiner' Other: Hospital: 1 ☐ Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Dealt After 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 2 Mame and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MES State filed (Month, Day, Year State DEC 0 3 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year loyner 6:12 Medical 4a. Facility Naine (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltinore
If Under 1 Year If Under 24 Hrs. Utim aven . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 1 XM 2 - F 245-32-7403 NC 11-13-1926 86 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f shoveny injury or other traumatic event, the Medical Examiner must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1616 LORMAN CT. 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Yes 2 □ No If Yes, Give Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION WORKER BUILDING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RAY ALEXANDER STACIE JOYNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1213 N. CAROLINE ST. BALTIMORE, MD TIMOTHY TOWNSEND / SON 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11-30-2012 BALTIMORE, MD 21. Sona Prineral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Lannunco disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Hospital or Attending Physician: The lew requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No this certificate has been signed by the arral director, page 2 should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No Yes 2 No 1 Yes Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de e Funeral Directo sletely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OHIO) 12 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

DEC 0 3 2012

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ nin MOV Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7236 Mockingbird Circle Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 437-47-7296 86 (Month, Day, Year) **Director** 1 🗆 M 2 🔀 F 12/21/1925 Korea Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Md. Anne Arundel Glen Burnie 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7236 Mockingbird Circle 21060 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 M Widowed 4 Divorced Completed Specify: Korean Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 should be filed with and Mental Hygier 7 is marked other t Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health ar Important: If Item 27 is Jong OK Kim (Daughter) 7236 Mockingbird Circle Glen Burnie, Md. 21060. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place injury or 12/03/2012 4 ☐ Donation 5 ☐ Other (Specify) Marriottesville, Md. Crestlawn 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Fundal Service Licenses Svkesville.Md. 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each_line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to infracdiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence orgaattending physician and for use as the burial-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year detached 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to edical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral c 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the I only one) 3 Certifying Nurse Practitioner: To the p est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jacqueline 28912 KIT Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death SECOURS Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 217-50-27 Hours Country) Director 1 🗆 M 2 🛛 F York New ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dapertment of Health and Mantel Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinal manter maining. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD bingdon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2100 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DEPT OF Agriculture eypunch perator 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Meredith Mayfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 110/12 12 Baltimore, Md remation CTR of 4 Donation 5 Other (Specify) Signature of F 22. Name and Address of Facility VAUGHN GREENE FINERIAL SKS 4905 Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Metastatic Immediate Cause (Final Breast Physician/ month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit or Attending Physician: The law raquires thet the daath cartificata ba axacutad that initiated events Due to (or as a consequence of): resulting in death) Last After this certificata has been signed by the attanding physician a funaral diractor, paga 2 should be datached for use as tha buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 18 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown To the Hospital or Attending Physician: The law raquire within 24 hours aftar death.

To tha Funeral Director: After this certificata has been si complataly filled in by tha funaral director, paga 2 should No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1. Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check re and title of cer 29d. Date signed (Month, Day, Year, 11/30/12 5691 100 Da15 eted cause of death (Item 23a) (Type, Print) 69 N. Charles 18W50W 31. Date filed (Month, Day, Year)

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			For State Registrar	amend 10	e, pe	Cer	tificate of	Death	in IVI	ептаг пу	Reg. N	.20	12	38848
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	Funeral Director			7. Age		t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		Counti	ace (State or Foreign y) YLAND
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	the Mar or 28a oe notifi	I Director	10e. Street and Number 1201 M			101 00	10f. Zip Code		220	<u> </u>	_		What Count	1X Yes 2 □ No ry?
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.		1	f Yes, specify Cuba	an, Mexicar	i, Puerto P	lican, etc.)			e - America ck, White, e : WHI	tc.
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Marr 3 ᡌ Widowed		Armed 1 7 Y	ecedent End Forces? Yes 2 X 1 Give r Dates.		ŀ	Vas Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2X No Specify:			cify Yes or No- Rican, etc.)	Black, Wh			etc.	
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	6		30. Name and addre	ess of person	who completed c	ause of de	ath (Item 2	23a) (Type, P	rint)	200	952.						
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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Khana Klig 0530 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 216-27-7734 1 □ M 2 🗓 F 103 12/31/1908 Ukraine Hygiene. other then "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 【 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien Item 27 is marked other the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) Korostik (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Klig - Son 706 Kersey Road, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it eny injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/03/2012 Olney, Maryland Judean Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ig physician and as the burlat-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.

Within 24 hours after death.

The Funeratel Director. After this certificate has been signed by the ettending I completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Myocardial Infarction 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signatur 29d. Date \$igned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Prtina Haag, 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D.,

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CNEMBER 29 AMPERT ernic 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death EDENWALD TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1/27/1922 Director PENNSYLVANIA 165-12-8638 1 🗆 M 2 💢 F 90 show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f MD BALTIMORE TOWSON 1 Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 800 SOUTHERLY ROAD 21286 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Tyes 2 No Specify Specify: WHITE 3 X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4 or 5+) PROFESSIONAL BALLET DANCER BALLET STUDIO 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HERMAN FINKEL RACHEL REES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 si ment of Health a LORI LAMPERT/DAUGHTER 900 BIG MOUNT ROAD THOMASVILLE, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 12/05/2012 4 Donation 5 Other (Specify) PRINCETON CEMETERY PRINCETON, NJ 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Frff 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Sepsis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or injury anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760% Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ BIPOLAR DISORDER Records, 2 → No 3 ☐ Probably 4 ☐ Unknown Completed HYPOTHYROIDISMI 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death Check only one) 1 ☐ Yes 2 ☐ No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 6701 NORTH CHADLES STRUET BA State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7. Age (In yrs. last birthday) Johns Hookins If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-64-5680 Director 1 ፟M 2 □ F 55 Nov 3, 1957 Maryland 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 1422 Holbrook Street 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify. black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 laundry facility laundry equipmt operator Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1653 Winford Road Baltimore, MD 21239 Pamela Loney injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 K Other (Specify) in 21. Signature of Funeral Service Licenses ²S Name and Address of Facility Board 655 W. Baltimore Street Director any m Baltimore .MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemocr disease or condition Medical resulting in death) Due to (or as a consequent Examiner enge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 L 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director: After this certificate letely filled in by the funeral director, pag 2 🗌 No 1 Tyes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Hospital: ျု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending Natural work?
1 Yes 2 No Accident Investigation Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 To the P only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Griffin, M.D. 1000 Orleans St. Bullinure

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DYYAM 201 Medical Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death Juseti + MOVE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funera! 213-46-9873 Director 1 🕅 M 2 🗆 F 66 June 6, 1946 New York 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a301 mcMechen Street #1115 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white "natural", 3 Widowed 4 X Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) self employed real estate/property Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred D. Lindsey Vera M. Lindsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is
any injury or other trau Marcus Lindsey/son Phoenix Mill Place Alexandira, VA 22304 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of tuneral Service Dicensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street <u>2120</u>1 <u>Baltimore, MĎ</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failure. List only one cause pn each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** V Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for as a consequence of that initiated events resulting in death) Last use as the burialattending physician Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached the 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 2 No this certificate filled in by the funeral director, 25. Was case referred to medical Division of Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t 1 Natural 2 Accident 5 Pending 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🖟 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Name and address of person Baltimer, Maryland. Lacu 31. Date filed Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

AMEND PI LINE A, 25, PER ME G933 11/29/12 TRT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and num Examiner 4b. City, Town, or Location of Death 112 Landing Lane Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 □ M 2 💢 F 217-64-4243 59 June 24, 1953 Maryland ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Cecil Elkton 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Landing Lane 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: and 2 should be filed within 72 hours aft Health and Mental Hygiene. em 27 Is marked other than "natural", 3 🗌 Widowed 4 🗎 Divorced white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Francis McClellan Mary Doloris McDowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald F. Murray/spouse 112 Landing Lane Elkton, MD permit. Page 1 and 2 Department of Healt Important: If Item 2: any Injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Euneral Service Dicensee Ronald So. We 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 irector 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hemorrhage COMPLICATIONS OF STROKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatly? þv Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 2 2 🗌 No 1 🗌 Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns RujapathenD D0057465 10/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldmore MD 1 203 NSKAJAPAKSEMD 7835 Smith AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ا عالالع Baltimore,	ge 1 and nt of Heal : If item 2		20a. Method of Disposition 1 Burial 2 Cremation 3	, –		ace of Disp	position (Na	me of		Date Date	20c.	Location - City o	•	_
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<i>\?</i> }\}	Physic this ce ral dire	2	examiner? 1 X Yes 2 X Yes 27. Manner of Death	Hospital:					4 ∐ Nursing	Home 5 ☐ Re	sidence	6 ⊠Other (Spec	ity HOSPICE	
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			30. Name and address of person who BRANDON COAYLEY IN					าปล	11 1.1761	V5 N505	Ms	RAITIMA	E, MD ZIZIS	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	e			W DEC	·cooke	MVC;	BAIDHARDE	5 1111 61618	
	Registra	r	DEC 0.3.2	012 Done	4 1	1. 4	ark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esther bernice 5:00 DM 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death 4362 Pine Field Sandall Stown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 1 🗆 M 2 🔀 F MD 19/1933 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Kandallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4362 Pine Field Court 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceuent Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Specify: African 21215-0036 1 ☐ Yes 2 No Specify: I Hygiene. other than "natural", 3 Widowed 4 ☐ Divorced Completed American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore Con College (1-4 or 5+) Elementary/Secondary (0-12) Officer 12th grade Correctional Jail Be Maryland 17. Father's Name First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Sumarne) Simpson Adams uvenia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Warfield Pino Field Court Randallstown MD 21133 /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Ring Memorial Park 12/06/2012 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Naughn C. Greene Funeral services 8728 Liberty Road Randallstown MD 2433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart jailure. List only one cause on each line.

Immediate Cause (Onset and Death Physician/ ementi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown r this certificate has been siveral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' ☐ Yes 2 No 1 ☐ Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 NO Other: in 24 hours and, the Funeral Director; After this contactly filled in by the funeral directly filled in by t ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Vovember 29, 2012 D00525f3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blud. Baltimore, MD 21239 David J. Nammer 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

/ DHMH 17 Rev 06-2011

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 1910 M Herbert Morsha-Taylor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-80-1068 Director 1 🛛 M 2 🗆 F Yrs 09/29/1952 60 Sierra Leone Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9722 Hedin Drive 20903 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. ۾ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Analyst Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pe Herbert Taylor Gladus Cole and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9722 Hedin Drive, Silver Spring, Maryland 20903 Madline P. Morsha-Taylor/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 g Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State George Washington Cem 12/08/2012 | Adelphi, Maryland 4 Donation 9 Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Venous Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Elevation Myocaedia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/X No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0071147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are Takana Pack, NO Carroll 7600

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MOV Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 212-39-5942 1 🗆 M 2 🗓 F 82 06/30/1930 UKRAINE 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 V No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6988 MARSUE DRIVE, #2B 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🗶 Married ۾ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced Specify. Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SECRETARY GEOLOGIC SOCIETY Be ige 1 and 2 should be filed nt of Health and Mental Hi i: If item 27 is marked ott 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SOLKOLOVSKY MOYSEY MARIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VLADIMIR MALAMENT/HUSBAND 6988 MARSUE DRIVE, #2B, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 11/30/2012 OWINGS MILLS, MD Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) LARIAN Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate I ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and attle of certifier pleted cause of death (Item 23a) (Type Print) and address of person who co

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

			amend #20a-c Please Typ MEND # 11,12,15-19BSt 1-State Registrar Amend #9,	&22 Per Flee or Print in	H G934 Black Ir	12/14/20 delible In)12 Jh k. Ensure	All Copie	es Are L	.egible.	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs			9. Birth	nplace (State or Foreign
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.e	f and fiftem 2		Bon Secours Hospita: 20a. Method of Disposition	20b. F	lace of Dispos	sition (Name of		Date Dal		ion - City or T	
Baltimore, Maryland 21215-0036	Page Tent o ant: If ury or		1 ☐ Burial 2 XX Cremation 3 ☐ Remove 4 ☐ Donation 5 █ O ther (Specify) 111		antic	natory or other place Crematory	y 12/0	08/2012	Glen	Burni	e,MD
Balt	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License, ROTI 1 d	hirector	S	Nume an Add	ss of Facility	d 655 W	Halt	imore l	Street Allen PA
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,	hysician/		shock or heart failure. List only one caus Immediate Cause (Final disease or condition	e on each line.	elv						Interval Between Onset and Death
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் ர Records, P.O. Box 68760	ne dear / the at ched f	Physician/Medical	1 Ves 2 No	☐ Pregnant at time of d☐ Unknown	leath 5 □	Other (specify)				Month	Day Year
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~ <u>e</u>	ian: Th rtificat ctor, pe	a l	25. Was case referred to medical			26. Pla	ace of Death (Che		2 X No	1 🗌 Yes	2 No
ر ک ب	hysici his ce al direc	To B	examiner? 1 ☐ Yes 2 → No Hospita	1 1 Inpatient 2 _		3 DOA Othe	er: 4 Nursing H	lome 5 🗆 Res	idence 6 🗌	Other (Specif	y)
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:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To Medical Examiner: On Certifying Nurse Pract	the basis of examination	and/or investi	gation, in my opinio	n. death occurred:	at the time, date	and place, and	d due to the ca	ause(s) and manner stated.
-	To the To the complete of the		29b. Signature and title an eartifier	MI		29c. License				gned (Manth,	
			80. Name and address of person who complete	ad cause addacth /lt-	230) / == - =	100	055243	2	//	13/70	7/
١			80. Name and address of person who complete	LEY (Item	23aHype, Pr	West.	Biltinon	1 tect	BATIO	ITE MA	2/213
	Stat Registra		DEC 0 2012	82./Registrar's Signat	ure	Colled					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla					1ental Hy	giene	010	22250
	_		Registrar	Loot		Cer	tificate o	f Death		i	Reg. No.	. U 1 2	38860
PI	hysicia	n/	Decedent's Name (First, Middle							Date of De Month	Day	Year	3. Time of Death
~. ·	Medio Examin		Alan Preston 4a. Facility Name (if not institution)		ımber)		4b. City, Towr	orLocation	of Death	Novemb		2012	8:10 AM M
<i>.</i>	zxamm	eı	64 Wakefield				Hager		O Death			unty of Death	
Fı	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Bir	th	hingto 9. Birth	nplace (State or Foreign
	rector		220-78-5425	1 🌠 M 2 🗆 F	50	Yrs.	Months Da	ys Hours	Min.	(Month, Da Mar 3,			intry)
p	how	ř	Usual Residence of Decedent 10a. State 10b. County			ity, Town or Loc	ation			mar 5,	1902	Mal	yland 10d. Inside City Limits
arylar	a-f s ified	ectc	MD Washi	ngton		Hagers							1 Ves 2 No
the M	or 28 e not	Ę	10e. Street and Number				10f. Zip Cod	e			10a. Citizen	of What Cou	
with	s 23a ust b	Funeral Director	64 Wakefield R	oad				2174	0		Ü	USA	
death	item:	Fun	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13. V	Vas Decedent o Yes, specify Co	f Hispanic Or	rigin? (Spe	cify Yes or No-		Race - Ameri	
after a	l", or kamir	Completed by	1 Never Married 2 ☐ Marria 3 ☐ Widowed 4 ☐ Divorced	ried 1 Tyes If Yes, G	ive 2 💢 No		☐ Yes 2 💢			induit, oto.j		Black, White, ecify: wh:	
Z1Z15-0036 within 72 hours after giene.	atura cal E	etec		Year or I	Dates.		ent's Usual Occ						
כר? 127 ה	an "n Medi	dm	(Specify only highe Elementary/Secondary (0-12)	st grade complete	d) (1-4 or 5+)	(Give k	ind of work dor NOT use retire	ne during mos	st of workii	ng	166. Kind o	of Business/Ir	naustry
withii giene	t, the		11	College		1ab	orer				consi	tructi	on
Maryland 2 should be filed th and Mental Hy	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L	,				18. Moth	ner's Name	(First, Middle,	Maiden Surn	ame)	
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	narke	-	Robert Carlt		s Sr	-				atherin			
Ore, Marylal 11 and 2 should be of Health and Ment	27 is r traur	1	19a. Informant's Name/Relationsh Carol Kane/si			100	g Address (Stre akefiel					n, State, Zip 21740	Code)
and Heal	other		20a. Method of Disposition		20b.	Place of Dispos	sition (Name of	- :		ate		ion - City or T	own. State
mo Page	nt: If		1 Burial 2 Cremation 4 X Donation 5 Other (S		n State	cemetery, crem	atory or other p	olace)				, ·	,
Saltimore, bermit. Page 1 and Department of Hea	Important: If ite any injury or of once.	Ì	21. Signatur Roll 16 S		Director	22	Name and Add	dress of Facil	ity	l	D = 1 +	4	Charach
മെക്	트등등		until	11th	ZI ECTO		altimor		2120		. Bait	imore	Street
			23a. Part 1. Enter the disease, or shock or heart failure. List o	complications that nly one cause on	caused the dea ach line.	th. Do not ente	r the mode of d	ying, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Between
	ician/ edical	ı	Immediate Cause (Final disease or condition resulting in death)	a	uno (mer							Onset and Death
1	miner		resulting in death)	Due to	(or as a consec	quence of):							.,,,
*	861	ner	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	quence of):						_	
nted	ansit	ami	Cause (Disease or injury that initiated events									-	i
exec	igned by the attending physician and be detached for use as the burial-transit	dical Examiner	resulting in death) Last	Due to	(or as a conseq	quence of):							
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ertific	ding p	Ĭ	IF FEMALE:	23c If yes or	itcome of pregna	ancv							
death o	atten I for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	Birth 2 Fet	tal death 3 🔲	Ectopic pregna Other (specify)				23d.	Date of delive Month	/ery Day Year
the de	ached	hysi	g Unknown	9 🗌 Unl			- 10,000						
that	gned to	by P	Part II. Other significant conditio	ns contributing to	death but not re	sulting in the ur	derlying cause	given in Part	I.	23e, Did to	bacco use c	ontribute to t	he cause of death?
quire;	should b	ted								1 🗆 ነ	Yes 2 □ N	o 3 🗆 Pro	bably 4 🗌 Unknown
e law requires	e 2 sh	Completed by								24a. Was a autop	sy	prior to co	ppsy findings available ompletion of cause of
The T	pag.									1 🗆 Yes	rmed? 2 No	death?	2 🗆 No
ician	rectol	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				Place of Dea	ath (Check	only one)			
g Phys	eral di	<u>၉</u>	1 Yes 2 No	28a. Date	Inpatient 2 e of injury	ER/Outpatient 28b. Time of	3 DOA 28c. In	4		ne 5 Resid			y)
nding ath.	r; Arre	icat	1 Natural 5 Pending 2 Accident Investig		nth, Day, Year)	injury	W	ork? Yes 2		ou. Describe II	ow injury occ	unca	
or Attendir fer death.	by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be 28e. Plac	e of Injury - At he ling, etc. (Specif		et, factory, offic	е	2			mber or Rura	l Route Number,
ital o list	led ir									City or Tow			
Hosp 24 ho	Fune etely f	Medical	(Check 2 Medical Ex	Physician: To the caminer: On the ba	sis of examinatio	n and/or investi	gation, in my op	inion, death o	ccurred at 1	the time, date ar	nd place, and	due to the ca	use(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Io the Funeral Director, Arter this centilicate has completely filled in by the funeral director, page 2		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitione	r; to the best of t	my knowledge, (at the time, da nse number	ate and plac			nd manner as	
			► 913 No	- Mr	d RAZ	171 M	0 0	0078	2-4	53	11/	19/19	
			30. Name and address of person w	ho completed cau	se of death (Item	n 23a) (Type, Pr	int) +	Holper	stow	MO.	217	Lici	
Re	Stat egistra	-	B1. Date filed (Month, Day, Year) DEC 0 3 2	012 En	Registrar's Signa	fare	2	0				4-0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3886 Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1 Shamsi Nasseri December 2012 2130 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Country) 579-11-2719 Director 1 □ M 2 🗶 F 89 June 02, 1923 Iran Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6530 Democracy Blvd. 20817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with. Department of Health and Mental Hygiene Important: if item 27 is marked other this any injury or other traumatic monce. School Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Habibolah Nasseri Amirzadeh Homauni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20814 Sima Troncone - Daughter 5225 Pooks Hill Road, #1210S. Bethesda, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/04/2012 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park . Signature of Funeral Service Licensee
Annen Guull Varku 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or I that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Jas

Be မ Certificate:

2130 pr

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No

29d. Date signed (Month, Day, Year)

December 02, 2012

Yes 25. Was case referred to medica 26. Place of Death (Check only one) 1 🗆 Yes 2 🗶 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide

City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Neme Practitioner: To the best of a pile calledge 29b. Signature and title of

D26259

30. Name and address of person who completed cause of death (Itan 23a) (Type, Print)

M.D., 8218 Wisconsin Avenue, Bethesda, Maryland 20814 Ava Kaufman. 32. Registrar's Signature

State

Director: After this certificate

within 24 hours a

To the Funeral C

Medical

To the Hospital or Attending Physician:

NASSERT,

31. Date filed (Month, Day, Year) DEC 0 3 2012 Registrar

12-08776 Charles Wesley		ens State	or Print in Black e of Maryland / De		f Health ar		l Hygiene	2012	38362
Physicia	_	Registrar 1. Decedent's Name (First, Middle,L			204		2. Date of De		3. Time of Death
Medical Exami	ner	Charles Wesley						Day Year er 18, 2012	1654 hrs
		4a. Facility Name (if not institution, g Peninsula Regional Med	·	1	4b. City, Town, o Salisbury	r Location of [Death	4c. County of Deat Wicomico	h
Funeral				s. last birthday)	If Under 1 Ye	ar If Under 2	24Hrs. 8. Date of E	Birth(MM/DD/YYYY) 9. Bir	rthplace (State or
Director		218-50-2156	X, м 2 F	63 Yrs	Months Da	_	Min	Forei	
		Usual Residence of Decedent					0019	19, 1949 110	Lytand
w any		10a. State 10b. County		City, Town or Locat					10d. Inside City Limits
ne Maryland or 28a-f show fied at once.	햦	MD Wicomi	.co	Salisb	10f. Zip Code			40- Cities of Marie Co.	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	1213 Old Ocean	Ciry Road		2180	1		10g. Citizen of What Cou USA	intry ?
th with	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?				? (Specify Yes or Nuerto Rican, etc.)	No- 14. Race - Amer White, etc.	rican Indian, Black,
er dea			1 Yes 2 X No			o specify:	, , , , , , , , , , , , , , , , , , , ,	Specific	
urs afi ttural'	ģ	15. Decedent's Education (Specify	or Dates:) 16a. Deceder	t's Usual Occupa	ation (Give kin		Specify: wh	ite Industry
5 72 ho cal Ex	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life	e. DO NOT us	e retired)		
003(within jene.	Completed	10	0	super	intender			road cons	truction
115-1 filed al Hyg	Be C	17. Father's Name (First, Middle, Las John Wesley Owe					Name (First, Middle ie Mae Wi	, Maiden Surname)	
212 212 ould be Ment mark	일	19a. Informant's Name/Relationship		19b. Mailing	Address (Stre			umber, City or Town, State	e, Zip Code)
MD 12 sho th and th and umat	. [Tavy Burton/dau	ighter	334	DEar Dri	ive Sal	isbury, N	MD 21804	
S l ano of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3		b. Place of Dispos crematory or oth		emetery,	Date	20c. Location - City or	Town, State
Page Page ment c		4 X Ponation 5 Other Speci	y:						
Balt Sermit. Depart Impor		21. Signature of Figure 2. Signature of Figure 2.	on ad, Direct			-		V. Baltimore	Street
Physician	-	3a. Par I. Enter the disea e, or on	np ications that caused the de		1timore		1201 liac or respiratory a	rrest, shock, or heart	Approximate Interval
/Medical xaminer		failure. List only one cause on	each line. a. <mark>Oxycodone Int</mark>	oxicatio					Between Onset and Death
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	je	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	e of):					
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certificate be noting physici tree as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr		tal death 3			23d. Date of deliver	•
x 68 h certi tendin use as	iciar	past 12 months?	4 Pregnant at time of	Edeath	tal death 3 her (Specify)	Ectopic p	egnancy	Month	Day Year
Bo ne deat the at	hys	1 Yes 2 No 9 Unknow	9 Ulikhowh						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>a</u>	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause	given in Part I	. 23e. Did	tobacco use contribute to es 2 No 3 Pro	the cause of death? bably 4 Unknown
requi	Completed					<u>-</u>	24a. Wa		utopsy findings available completion of cause of
ecc he lav ate has	E						peri	formed? death?	· _
al R	BeC	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·	26.Plac		neck only one)		2
Vit	ᆲ	examiner? 1 ✓ Yes 2 No		✓ ER/Outpatient			lursing Home 5		r:
ding F	삥	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of I		ury at Work?	a1b-1-a-a	e how injury occurred t ingested (Oxycodone
Sion Attendi r death. ector: by the f	Certification:	2 X Accident Investiga	28e Place of Injury - A		IIIS —	Yes 2 X No			
Divi	탩	3 Suicide 6 Could not determine	t be		a, raciory, onice	bulluling, etc.	or Town,	(Street and Number or Rustate) 2507 01d (Ocean City R
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,		20a Cartifias	cian: To the best of my know		red at the time, o	late and place			
Fo the vithin. Fo the omple	Medical		er:On the basis of examinatio and manner stated.						
- > - 0	ž[29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mo	inth, Day, Year)

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

parke

30. Name and address of person who completed truse of de in (Item 23a)

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

Registrar's Signature

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

November 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 13 per fb e 934 12 3 Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV Day merica 30 4:00a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Examiner Ellicott City Health and Rehab. Ellicott City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Cuba 8. Date of Birth Funeral (Month, Day, 1 □ M 2**X** F 90 Director 579-70-6938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Sykesville Carrol1 1 Yes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Cuba Funeral 21784 7425 Village Road Apt. 16 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Latino 1 X Yes 2 X No Specify: Cuban 3 ₩ Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Distribution Factory Worker Be 18. Mother's Name (First, Middle, Maiden Surname)
Mariana Valera 17. Father's Name (First, Middle, Last) ည Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7425 Village Road Apt. 16 Sykesville, MD 21784 Maria Melcher/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD Ft. Lincoln Cemetery 12/3/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licens e Haight Funeral Home and Chapel, P.A. 6416 Sykesville Road Sykesville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ∉nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) **To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) ပ္ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.0. Box 2613 TRIZY Wolokolie 31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Physician/ Month ELIZABETH PRESBERRY lovembe 201 AGNES Medical 4a. Facility Name (if not institution, give street and number) 4b. Qity, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number If Under If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Age In vrs. last birthday. 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Hours Min Country) MARYLAND Yrs. **Director** 90 <u>216-28-1296</u> 17 1922 FER Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No MARYLAND HARFORD CO HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 835 ERIE STREET 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 X Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 📉 o Specify: "natural", Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th grade DOMESTIC N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOMAS CAIN KIZAH PRESBERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes E. Minor/Niece 835 Erie St., Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BERKLEY CEMETERY 11-30-12 DARLINGTON, MARYLAND 21. Signal of Funeral Service Linnsee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD BLVD. ABERDEEN. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ rem nale disease or condition resulting in death) Medical Due to (or as a correquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury Month the Hospital or Attending Physician: The law requires that the death certificate be executed OV that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent p egnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 No ate has reen signed by the atte page 2 should be detached for Month Year Day 9 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 🗸 24a. Was an . Were autopsy findings available autopsy prior to completion a cause of performed' After this certificate 1 Tes 2 🗓 Yes Division of Vital completed filled in by the funeral cirector, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier e signed (Month, Day, Year) 2 1 Name and address of person who completed cause of death (Item 23a) (Type, Print) Whe 32. Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Himore MEMORIAL HOSPITAL UNION 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 215-80-2309 Days Director 1 □ M 2 🛛 F ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 KOSEHILL ERRACE 21218 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten ا Examiner ا 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RIVATE vate Duty NURSING Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည ERRY 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD.21239 blewood AUBHTER or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12-8-12 podlawn Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VANOHN GREENE FINERING SWS oad. Plint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a nor section of offiburial-transi that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the burial Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🔲 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation after death 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HLOW 201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 29, LINDA M. PADDY 2072 7:50 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 213-26-5325 Director 82 1 □ M 2 🖾 F 5/5/1930 MARYLAND Usual Residence of Deceden or 28e-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Merylend Examiner must be notified at 10d. Inside City Limits Directo MD BALTIMORE 1 Yes 2 No DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 2912 DUNBRIN ROAD APT. B 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. "neturel", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed WHITE 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) itel Hyglene. ad other then " event, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) 8TH GRADE HOMEMAKER OWN HOME 8 17. Father's Name (First, Middle, Last) of Health and Mentel H litem 27 is merked of other traumetic ever 18. Mother's Name (First, Middle, Maiden Surname) ၉ CLYDE PADDY BLANCHE DRUERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA VEST/DAUGHTER 2131 WILKER AVENUE BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ŏ 1 Burial 2 1 Cremation 3 Removal from State cemetery, crematory or other place permit. Page Department of Importent: If eny injury or once. METRO CREMATORY, INC. 11/30/2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, 3521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) Nonsmall cell Cancer rears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam attending physicien end I for use as the buriel-transit To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burlel-transi Cause (Disease o. Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 🗡 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 De Other (Specify) NO>pc 1 Tes 2 🔀 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation М 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number only 58303 November 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 UNTILES S 6701 N. Chances

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Maureen Sheila Poston 200 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-42-2203 Director 68 1 □ M 2 X F June 30. 1944 England Usual Residence of Decedent 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director nit. Page 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygener artment is Health and Mental Hygener ordant; I fitem 27 is marked other than "natural", or items 23a or 28a-f si injury or other traumatic event, the Medical Examiner must be notified. WV Berk1ev 1 Yes 2 XNo Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 281 Imperial Way 25419 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo 1 Never Married 2 A Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Melvin Mvers Sheila Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julius H. Poston - Husband 281 Imperial Way, Falling Waters, WV, 25419 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donațion 5 ☐ Other (Specify) Meadowridge Mem. Park: 12/04/2012 Elkridge, Maryland Funeral Service Licenses 21. Signature 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 7250 Washington Blvd., Elkridge, Maryland 21075 Enter the disease, or heart failure List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock. Immediate Cause (Final Phymician/ disease or condition Medical resulting in death) Examiner Socue tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last physician Physician/Medical that the death certificate be as IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Pregnant at time of death 5 Other (specify) Day Year g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law autopsy performed 1 Yes Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A pletely filled in by the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Manuel Pizanis 7:12 AM DECEMBER Medical 2017 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 81 Hours 215-28-5772 Min. 8/18/1931 Mary Land Director 1 M 2 🗆 F Usual Residence of Decedent I Hygome.
I Hyghere in the matural", or itams 23a or 28a-f show yant, the Modicil Examination of the motified at 10b County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Timonium 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21093 815 Branford Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. δ 1 Never Married 2 1 Married 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Owner Be filad Baltimore, Maryland parmit. Page 1 and 2 should be filed Dapartment of Haatth and Mental Hy Important: If item 27 is marked oth any injury or othar traumatic evant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mike Pizanis Margaret Gaydash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Branford Circle Timonium, Maryland 21093 Mary Lou Pizanis / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place St. Demetrios Cem. Baltimore, Maryland 4 Donation 5 Other (Specify) 12/5/12 21. Signature of Euneral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Celler 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PULSELESS ELECTRICAL ACTIVITY ARILEST Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit PNEUMONIA signed by tha attending physician and d ba detached for usa as tha burial-tran: Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOGENIC SHOCK 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? LACTIC ACIDOSIS 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2. perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed Month, Day, Year) 024034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TIMOTHY LOW 7601 TOWSON 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 1130 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 2926 Hartord Baltimore Baltimore 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days (Month, Day, an 19, 1 □ M 2 🔯 F Months Min. Yrs Director 212-44-8850 68 1944 <u>Jan</u> Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 √ Yes 2 □ No MD Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Center Place #910 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Tes 2 No Specify: Completed 3 Widowed 4 X Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. ?**7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) 0 <u>book binder</u> publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Joseph Boehmlein Mary Zygmont permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Boehmlein/brother 5716 Denfield Road Rockville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of F cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 🕅 Donation 5 🖵 Other (Specify) 21. Signature of Funeral Solvice Licens Ronald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director in 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer set and Death Immediate se (Final disease or condition resulting in death) Physician/ neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine physician and the burial-transit that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 signed by the attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 | Yes 2 | 9 | Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 \square No Yes 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Hospital: 2 No 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie M087790 8 2012

State Registrar Name and address of person wi

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DHMH 17 Rev 7/2009

4940 Eastern Ave

Baltimore

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Robert Burton Ryder, Sr. NOV Medical 4:00 _p_ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death **Eldersburg** Carrol1 2066 Bandy Avenue Social Security Number 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours **Director** 85 048-20-7763 1 X M 2 - F Yrs JUNE 4, 1927 Connecticut Usual Residence of Deced or 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 🗓 No Maryland Carroll Eldersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2066 Bandy Avenue 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 I If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. 3 Widowed 4 X Divorced WWII White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) r and Mental Hygien is marked other the Pharmaceutical Rep. Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Howard Ryder Lillian Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Healtl Important: If item 2 any injury or other tonce, Robert B. Ryder, Jr./son 2066 Bandv Avenue Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 11/30/2012 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Haight Funeral Home and Chapel, P.S. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) erbert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ o Cardi disease or condition resulting in death) Medical Due to (or as a cons a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completely filled in by the funeral director, page 2 autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No Yes 1 Tyes Division of Vital 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner o ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury 2 No Accident
Suicide 1 Yes Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 30, Name and address of person Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3887 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 890,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Security Number **Funeral** 7. Age (In vrs. last birthday) If Unde If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Country) 82 **Director** 212 36 7756 1 ₩ M 2 🗆 F Yrs July 25, 1930 Usual Residence of Decedent Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exertiner mest be notified at 10b. Count Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Middle River 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9724 Conmar Rd. 21220 USA Was Deceden.

Armed Forces?

1 № Yes 2 □ No Give 1951/55 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ξ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Horticulturist Wholesale Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William Scott Ritter Catherine Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Helen J. Ritter (Wife) 9724 Conmar Rd. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite eny Injury or oth Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗋 Removal from State Holly Hill Mem. Gardens 12/5/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland permit. 21. Signature of Funeral Service Licens 87 Nama and Address of Facility Bruzazinski funeral Home P.A. 1407 Old Eastern Avenue Essex, okn n Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician To as a management of): Discare disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the ettending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the, use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the et id be detached for Month Day Year Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Records, 1 🗆 Yes 2 🗆 No 3 🗗 Probably 4 🗆 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has yes 2 No After this certificate 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division I Director: A 1 Yes 2 No death. 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 24 hours after of Funeral Direct 28f. Location (Street and Number or Rural Route Number, the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) ANS STREET, BALLIMORE, MD Beat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2012

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daniel John Ruberti, 2nd November 11:02 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 022-46-5809 Director 1 X M 2 □ F 57 Yrs. Oct. 19,1955 Michigan permit. Pege 1 and 2 should be fliad within 72 hours efter death with the Maryland Dapartment of Haelth end Mentel Hyglene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show eny injury or other treumatic evant, the Madical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Tyes 2 No Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1116 Halstead Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 ☐ Never Married 2 🕅 Married 1 KN Yes 2 □ No If Yes, Give1 978 – 1984 Year or Dates. 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunication Engineer Computer Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ruberti Patricia MacKenzie Daniel J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Maryland 21234 1116 Halstead Road <u>Maria del Carmen Ruberti</u> Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12-3-2012 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 21204 1050 York Road Towson, Maryland au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Aryna disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami I or Attending Physician: The lew requires that the death certificate be executed effer death.

Director: After this certificate has been signed by the ettending physician and that initiated events burial-tre resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 ettanding properties IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 □ No 3 □ Probably 4 □ Unknown is certificete has been sl director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ANo Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) ٩ To the Hospitel or Attending Physi within 24 hours efter death.

To the Funerel Director: After this c completely filled in by the funarel dir 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending 1 🗌 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my reliable death. 29a. Certifier 2 deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.
2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 deficial Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day,

701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **22** Physician/ Month ROUSE JOSEPH 1042 NOVEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death VORTHWEST HOSPITAL RANDAUSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 0980 8. Date of Birth (Month, Day, Yea June 28, 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) 1 🕅 M 2 🗆 F Days Hours Min Director 213 - 14 - 0993 Usual Residence of Decedent or 28a-f show be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 No Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 8811 Flagstone Drive 21133 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 ♥ Widowed 4 □ Divorced 41-71 Specify: white Completed Year or Dates. th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ attorney government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o Birckhead Rouse Anna Margaret Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Page 1 and 2 8811 Flagstone Drive Randallstown, MD James H. Rouse/son 21133 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ō ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 X Donation 5 ☐ Other (Specify) want age Ronald State Anatomy Board 655 W. Baltimore Street Director my Baltimore. MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 3 DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by PANCREATIC CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION 24a. Was an Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performed? death? ACUTE RENAL FAIWLE 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nursy Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0060193 wo 2012 NOVEMBER 21 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) PANDALLSTOWN COURT RD. 5401 OUD M.D MD 21133

State Registrar 31. Date filed (Month, Day, Year)

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336	al", c	d b	3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, Give Year or Date		1.6	☐ Yes	2 💢 No	Specify:				Specify:			
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yla	ld be Ment arke	욘	Oscar Robey							Marg	aret S	tagg	gers			
Maryland 21215-0036	shou and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	er or Rural	Route Numbe	er, City o	or Town, Sta	ite, Zip C	ode)	
o o	and 2 lealth em 27 her t		Selma Robey/spo	use		419	Russe	211 A	venu	e #11	6 Gait	her	sburg	MD	20878	
0	ge 1 st of F		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from S	20b. f	Place of Dispos cemetery, crem	sition (Nan	ne of			ate		Location - C			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 🛛 Donation 5 🗆 Other Spe	cify)												
Bal	permi Depar Impor any ir		21. Signature of the rail Service Lice	Wade, D	irector	22. St	Name an	d Address	s of Facility	y	655 W	D o	1++			
		- 13	Man Port 1 Notes the disease	M		Ba	Itimo	ore,	MD D	<u> 21201</u>	655 W.	ра	T C TINO	re St	reet	
			23a. Part 1. Enter the disease, or co shock, owneart failure. List only Immediate Cause (Final	one cause on each								rest,			Approximate Interval Between	
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	Hence off:		_						+		
	ecuted and i-transit	֓֓֓֓֓֓֓֓֓֟֟ <u>֟</u>	cause, Enter Underlying Cause (Disease or injury													
	be executed sician and burial-transi	cal Examiner	that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of):										
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Bo	death	sici	in the past 12 months?	4 ☐ Pregna	int at time of o		Other (sp						Mont	h [Day Year	
P.O. Box 6876	requires that the des been signed by the s should be detached	Æ	9 Unknown								_					
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rds	een s een s	Completed by					·				1 🗆	Yes 2	2 □ No 3	☐ P roba	ably 4 🖾 Unknov	wn
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>	Physical this call dir	5	1 Yes 2 No	1 4 In		ER/Outpatient			4 ∐ Nu	rsing Hon	ne 5 🗆 Resid	lence	6 Other	(Specify)		
0	ding h. After fune	ate	1 ⊈Natural 5 ☐ Pending		injury Day, Year)	28b. Time of injury		Bc. Injury : work?			8d. Describe h	ow inju	ry occurred			
Sio	deat deat ctor: y the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	be One Diese of	Injuny - At ho	me, farm, stree	M		′es 2 □ I							
Division of Vital Records,	after after Direction b		4 Homicide determined	building	, etc. (Specify)	et, factory,	опісе		2	8f. Location (S City or Tow			or Rural F	loute Number,	
	Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. 14 hours after death. 15 hours Director: After this certificate has been signed by the attending physetely filled in by the funeral director, page 2 should be detached for use as the	ica	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowl	edge, death or	curred at	the time.	date and r	place and	due to the ca	nico(c)	and manner	as states		- 13
	To the Hospital or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis	of examination	and/or investig	ration in m	v oninion	death acc	numer of the	no timo doto o	nd alaa	a and due to	- Alea	-(-)	ated.
i	vithi To #		29b. Signature and title of certifier		_	-	29c	License r	number			20-1 D	ate sine ad /	donath Di	Vel	
	,		1/1	M	P			D6	81.78			(1)	18/12			
	`		30. Name and address of person who	completed cause	of death (Item	23a) (Type, Pri	int)		111 - 5	` '/	0 .1	. 11	· AA	1-1	250.20	
			/TIEX KINNGI	MD MD	9401	Medic.	al	cen-	ter 1	m	Jeo Cli	ا ا ا	1 10 (0)	11704	20820	
	Stat Registra	e ir	30. Name and address of person who At Ex Kinn and 31. Date filed (Month, Day, Year)	12 Reg	strar's Signat	Lan.	Kel									

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November 17,2018

Robery, Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Richardson Joseph November 18 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death + Behabilitation UT timore ursina 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Director 219-26-5975 1 🕅 M 2 🗆 F 73 Usual Residence of Decedent Jan 31 Maryland 2 should be filed within 72 hours after death with the Maryland the And Maryland Hyghan. St lis marked other than "natural", or items 23a or 28a-f show traumatic event, the Misclical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√L Yes 2 I No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Frankford Avenue 21206 USA 12. Was Decedent Ever in U.Sunk Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 8 Baltimore, Maryland 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Haalth Item 27 I Frankford Nursing & Rebab Ctr 5009 Frankford Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1
Dapartment of I
Important: If It
any Injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🔀 Other (Specify) 21. Signature of Funeral Convice Licenses 22. Name and Address of Facility State Anatomy B Baltimore, MD tate Anatomy Board 655 W. Baltimore Street altimore, MD 21201 m 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Demention disease or condition resulting in death) Yrans Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attanding physician end I for usa as tha burial-transit or Attanding Physician: The law raquires that the daeth cartificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year signed by the a 1 Yes 2 D 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Heart 1 Yes 2 No 3 Probably 4 Unknown , certificata has baan si, lirector, paga 2 should l 24b. Were autopsy findings available prior to completion of cause of death? Dychhagie. 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital tha funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Aftar this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attanding within 24 hours aftar daath.
To the Funeral Director: Afti complataly filled in by tha fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier

State Registrar

only one) 29b. Signature and title of certifier

Dunial

31. Date filed (Month, Day, Year)

W7

405 N.

2. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 3 2012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Balkimore

29d. Date signed (Month. Dav. Year)

21201

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Him N/A**Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 218-94-4459 Director 1 X M 2 □ F 63 04/02/1949 RUSSIA ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12111 LONG LAKE DRIVE 21117 USA ## Jean 2 should be filed within remember 1 and 2 should be filed within remember 1 is marked other than "natural", or items? items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: 3 Divorced Completed WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) OWNER IMAGE PAINTING COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL ROYFER SONYA RUBINCHIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER ROYFER/WIFE 12111 LONG LAKE DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 11/30/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease shock, or hearthilure. Li disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause 11 EPSIS Physician disease or condition Medical resulting in death) Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of): Exam sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item cans st. Baltimore. ERIK

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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3 Registrar's Signa

RIEGELHAUPT, KALMAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death amaritan 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 220-64-919 Director 1 DM 2 DF 56 Yrs. -1956 MU item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Ymore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3222 21239 ome Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: Blac Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, မ Page 1 and 2 should of Health and Nitem 27 is ma formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Baltimore, 20a. Method of Disposition Place of Disposition (Name of 20b. 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Tanover 21. Signature of Funeral Service Licensee 22. Name and Address of Facility . Greene Funeral Berukes 905 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence oily the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transif and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Yes 2 No 1 Yes 2 Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has prior to death? performe 1 ☐ Yes 2 ☐ No Yes 2 No eral Director: After this certifica filled in by the funeral director, i 25. Was case referred to medical 8e 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 🗌 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury / (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death of at the firme, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of M	laryland / [Departme Certificat			lental Hy	giene	012	388	79
			Registrar 1. Decedent's Name (First, Middle,	Last)	-	Ceruncai	e or Dea	atri	2. Date of De	Reg. No	012	3. Time of D	
	ysicia Medio		Joseph.	Sims					Month	Day	2012	1:10	
	xamin		4a. Facility Name (if not institution,	111	\sim i.	4b. City	, Town, or Loca	ation of Death	,		nty of Deat		•
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	neral ector		358-26-5083	6. Sex 7. Ag	e (In yrs. last birth	Months		nder 24 Hrs. Jurs Min.	8. Date of Bi (Month, D.	ay, Year)		hplace (State or F intry)	Fo <i>rei</i> gn
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ryland	edat	cto	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City	
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eath	er m	Ē	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Dece	21001 dent of Hispan	nic Origin? (Spe	cify Yes or No-	U.S.A		ican Indian,	
36 after 0	amin o	þ	1 Never Married 2 Marri		No		city Cuban, Me 2∰ No Sp	exican, Puerto I	Rican, etc.)	В	lack, White	, etc.	
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ould b			GRUNDY SIMS 19a. Informant's Name/Relationshi	n (Tima Print)				L.V. SC					
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of Head			20a. Method of Disposition		20b. Place of	03-2B Wisposition (Na.	ne of		<u>berdee</u> ate	n Md 20c. Locatio			\dashv
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	dical		disease or condition resulting in death)	a. Due to (or as	SULLA a consequence of	Taly	INSU	VTIC	ENCY		-	Onset and Dea	aus .
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6/60 ificate b ig physi	as the	Medi	IF FEMALE:	0									=
BOX 68 death certifi	or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregnancy 2 Petal death	3 🗆 Ectopic	oregnancy			23d. E	Date of deliv	/ery	
e dear	ped f	ysic	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (s)	pecify)			N	Nonth	Day Yea	r
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Attending r death. ctor: Afte	e fun	igat	1 Natural 5 Pending 2 Accident Investiga	(Month, Day	Year) inju	ıry M	work?		sa. Describe r	ow injury occu	rrea		
r Atte ter de recto	ي أ	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, fam	n, street, factory	, office	2			ber or Rura	l Route Number,	
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Hosp 24 ho Fune	etely	Medical	(Oriect 2 Li Medical Ex	hysician: To the best of raminer: On the basis of ex	amination and/or i	nvestigation in i	ny opinion dea	ath occurred at t	he time date a	nd place and d	un to the on	unala) and manna	er stated.
Division of vital mecords, F.O. box 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in	сошр		only one) 3 ☐ Certifying N 29b. Signature and title	lurse Practitioner: To the	best of my knowle	edge, death occ	rred at the time License numb	e, date and plac	e, and due to t	he cause(s) and 29d. Date sign	manner as	stated.	
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			30. Name and address of person wh				16		-	1700-2011	DOWN C	1 901	4
			novies Hols		Mary la	nd Heal	thraif	2 yste	m, te	vry to	int,	mD219	02
Rec	State gistra	r	31. Date filed (Month, Day, Year) NFC. 0 3 2012	32. Registral	Signatura				,	Û			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b,c per th 8937 3-13-13 vt. State of Maryland / Department of Health and Mental Hygiene 38880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03:38 M M Sines enise 11 2019 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balkmore Manyland Medical University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Director June 8,1963 218-92-1156 1 M 2 XF Washington DC Usual Residence of Decede . Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 X No Frederick MD Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5837 Detrick Rd. U.S.A. 21771 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) self-employed/legal ulth and Mental Hygien 27 is marked other the r treumatic event, the Title abstractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည å Paul Ponton Sybil Lowe permit. Page 1 and 2 should be Department of Health and Men Importent: If item 27 is marke any jointy or other treumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Sines - husband 5837 Detrick Rd., Mt. Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of Restrictory, crematory or otherplace)
St. Peter's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Frederick
-Libertytown, MD 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd., Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Physician Distress Agrictione Medical Due to (or as a consequence of): Examiner Panercelitics Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 202 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 202 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? 1 Ves 2 No To the Hospital or Attending r-mysruan. within 24 hours efter death.

To the Funerel Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 I Yes ည 1 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) methon 13 H 11/27/2012 447021539

Registrar

DHMH 17 Rev 06-2011

State

Jonathan

31. Date filed (Month, Day, Year)

DEC 0 3

13

Bultimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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II.	within 24 hours effected. To the Funeral Director: After this certificate has been signed by the ettending physical completely filled in by the funeral director, page 2 should be detached for use es the but	Medical	(Check 2 L Medical Exa	hysician: To the best of miner: On the basis of e	kamination	and/or invest	tigation, in my opinic	n, death occ	curred at th	e time, date a	and place, and o	due to the ca	use(s) and manner stated.
To the	within comp	2	only one) 3 ☐ Certifying N 29b. Signature and title of certifier	urse Practitioner: To the	e best of m	y knowleage,	29c. License		and place		the cause(s) and 29d. Date sign		
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			30. Name and address of person wh	completed cause of d	eath (Item	23a) (Type, F	Print) OR al	anna	6.	N	7.0	Cir	NID 21/14
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TOD 1030

M 800281200 Schulzke, Eva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ AM Medical Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death **Examiner** 4c. County of Death 00 MOV Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 🗹 F 89 Months Hours Min. Month, Day, Country) Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic event. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Pyes 2 No more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA vac 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 3/ac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dormar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State netery, crematory or other place timore 4 Donation 5 Other (Specify) lano. -2012 Signature of Funeral Service Licenses 22. Name and Address of Facility lebrak 905 21213 KOOD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to main clat-cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes Acciden 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Fig. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatuye the of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NFC 0 3

K1502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HILDA 3:49 pm Taylor November ∂Ö"\A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death elen Burnie Baltimore - Noshington Medical Contex Anne Anunce 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 219-28-4347 Director 1 M 2 SyF 82 Yrs. 10/25/1930 MD Usual Residence of Deceder show 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Experiment must be notified at 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Glenlea Dr. 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 N Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housewife Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve ance. Joseph Roland Cager Mary Jane Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Jackson (Daughter) 139 Faywood Ct. Apt.F Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Asbury Town Neck 12/6/12 Severna Park, MD 21. Signature of Funeral Service Licens Josephn H. Brown Jr. Funeral Home 2140 N. Fulton Ave. Balto., MD 21: me PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmorary Physician/ disease or condition resulting in death) & WEEKS Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and dedected for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 m nths?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown is certificate has been si director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? 2 No 1 🗌 Yes 1 🗌 Yes 2 N 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ပ္ 1 Nonpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 LY Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier au compression de Cumpression MO 00085511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEH BURNIE, NO 20161-5803 BUILLEHMO JOSE CIANGRECO 31. Date filed (Month, Day, Year, State 3 DEC 0 Registrar

/ DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental H

			1 - State Registrar		Cer	tificate of i	Death		-	1 2	38881		
	Physici	an/	1. Decedent's Name (First, Middle,	,				2. Date of De	Reg. No.		3. Time of Death		
-	Medi	ical		IOMPSON				NOVEMB1	ER 28,	2012	11:15P ^M		
	Exami	ner	4a. Facility Name (if not institution, the KESWICK MULTI-				r Location of Death		4c. Cour	ty of Death			
-	Funeral			6. Sex 7. Age (In yrs. la	ast hirthday)	BALTIN If Under 1 Year	10RE If Under 24 Hrs.	I o Data of Dia		-			
	Director		216-28-8858	1 X M 2 □ F 80	Yrs.	Months Days	Hours Min.	8. Date of Birl (Month, Da	y, Year)	Count	lace (State or Foreign ry)		
	land show dat	٦	Usual Residence of Decedent 10a. State 10b. County	10-00				APRIL	3, 1932		MD		
	arylar la-f sl	Funeral Director	MD 100. County		y, Town or Loc			10d. Inside					
	or 28 e not	قَ	10e. Street and Number	II	BALTIMO	10f. Zip Code					1 X Yes 2 No		
	with s 23a ust b	eral	612 RESEVOIR S	ST .		21217	7		10g. Citizen o		ry?		
	death items her m		11. Marital Status	12. Was Decedent Ever in U.S	3. 13. W		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-		USA ce - America	n Indian		
Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ted by	1	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Yes, specify Cuba		Rican, etc.)		ack, White, e	tc.		
15-(72 hou "nat edica	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Decede	ent's Usual Occupa	ation		16b. Kind of 8	_			
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/an	be fil lental rked ric ev	입	JOHN B. THOMPS				18. Mother's Name	e (First, Middle, I		ne)			
ary	should and N is ma		19a. Informant's Name/Relationship	(Type, Print)	19h Mailing	Address /Street a				_			
e, S	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important if item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		BERTHA JONES/S		2437	EDMONDS	ON AVE.	BALTIM(ORE, MD	State, Zip Co 2122			
Baltimore,	age 1 int of l	il	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State Ce	ace of Disposi emetery, crema	tion (Name of story or other place	e) [Pate	20c. Location	- City or Tow	n, State		
i ii	nit. Pa artme ortani Injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	ecify) MET	TRO CRE		11-3	0-2012	BALTIMO	ORE, M	ARYLAND		
Ba	permi Depar Impor any ir		ames a service Lice	msee — —	22.1	Name and Address	s of Facility JAM	ŒS A. M	ORTON 8	SONS	F.H., INC.		
		H	23a Part 1. Enter the disease or co	implications that caused the death.	Do not enter	U1-31 LA	URENS ST.	BALTI	MORE, N	D 21:	217		
ΡΙ سمر	hysician!		Immediate Cause (Final				, such as cardiac of	r respiratory arre	est,	2 I	Approximate Interval Between		
(5)	Medical		disease or condition resulting in death)	a. Due to (or as a conseque	ence of:	(A					Onset and Death		
	Examiner	ايا	Sequentially list conditions,	h	.,.								
7	sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	nce of):								
ecute	and I-tran	xan	that initiated events resulting in death) Last	C. Durate (or on a general									
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed	ng physician and	Medical	resulting in death, Last	Due to (or as a conseque	nce ot):								
8760 tificate b	g phy:	ledi		■ d									
x 68	endin		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					2015				
Box	ed for	Physician/	in the past 12 months?	1 Live Birth 2 Fetal of 4 Pregnant at time of dea		ctopic pregnancy other (specify)			23d. Da	e of delivery nth Da	ay Year		
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5, P	been signed by the attendir should be detached for use	b b	Part II. Other significant conditions	contributing to death but not result	ing in the unde	erlying cause give	n in Part I.				cause of death?		
ords requir	been	etec						1 🗆 Ye:	s 2 No	3 Probab	ly 4 🗆 Unknown		
Division of Vital Records, alor Attending Physician: The law requires	e has l	Completed by						24a. Was an autopsy	/ 1	rior to comp	findings available letion of cause of		
<u>E</u> ::	certificate har		5. Was case referred to medical						red?	eath?			
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of Ph	n. After thi funeral		7. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 ER	Bb. Time of	28c, Injury a	4 Nursing Hom	e 5 Residen					
ion	death.	13	2 Accident Investigatio		injury	work?	es 2 🗆 No	d. Describe flow	rinjury occurre	u			
IVIS or Att	olirect in by	Certificate:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		a, farm, street,	factory, office	28	Bf. Location (Stre	et and Numbe	r or Rural Ro	ute Number,		
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the Hos	within 24 hours after deatt To the Funeral Director: , completely filled in by the	Medical	(Check 2 Medical Exam	rsician: To the best of my knowledge niner: On the basis of examination and se Practitioner: To the best of my k	ge, death occu	urred at the time, or ion, in my opinion,	late and place, and death occurred at th	due to the cause e time, date and	e(s) and manne place, and due	er as stated. to the cause(s	s) and manner stated.		
70 th	within To the comple		9b. Signature and title of certifier	se Practitioner: To the best of my k	rnowledge, dea	29c. License no	time, date and prace	, and due to the	cause(s) and ma d. Date signed	anner as state	d.		
			▶ manu	orin		D 3	5102	- 1	juvem	Bev	29, 2013		
		2.1	D. Name and address of person who o	n m.D 591	01 00	with cl	tavlis	Stre	(B)	+16m	29, 2012 Up MAY		
	State	331	. Date filed (Month, Day, Year)	32. Registrar's Signature	par								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thuy 8:58 ам T. Vu 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 500 Hexton Hill Road Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Months 586-42-6790 Director 1 🗆 M 2 🗶 F 100 Yrs 08/17/1912 Vietnam 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Silver Spring 1 🗆 Yes 2 ី No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Hexton Hill Road 20904 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Mamied Asian If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cham T. Chu Landinh Vu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Heatt. Important: If item 2: any injury or other tra Kimthi Bui - Daughter 500 Hexton Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/10/2012 Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave.,Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): eral **Director**. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my orbitor death accounted at the cause of the cause 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) In MD D54486 NOVEMBER 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 New Hampshire Avenue, #310, Takoma Park, Maryland 20912 Huyanh Ton, M.D.,

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

DEC 0 3 2012

Baltimore, Maryland 21215-0036

Box 68760

Records.

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wisniewski November 2012 11:04 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dove House Westminster Carrol] Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 1 M 2 TXF 218-40-0410 70 8/16/1942 Maryland Usual Residence of Decedent i Hygiene. I other then "neture!", or Items 23e or 28a-f show vent, tre Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1524 Old New Windsor Road S. A. 21776 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 72 hours efter If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. Completed 3℃Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Medical Phlebotomist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 8 Ethel Bleaklev Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar importent: if item 27 is eny injury or other treu once. 1524 Old Windsor Road New Windson, Maryland 21776 Warren Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pege 1 12/6/2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutherville, Maryland Dulaney Valley Mem. Gard 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physicien: The law requires that the death certificate be executed ettending physicien end I for use es the burlai-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day 5 Other (specify) Year To the Hospital or Attending Physicien: The law requires that the cea within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detached to g Unknow a Dinknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 2 Accident 3 Suicide 5 Pending Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 103 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

DEC 0 3 2012

12-09136 June Denise Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	·		Certific	cate of	Death			R	eg. No	D.		
Physicia Medical Examii	ın/	Decedent's Name (First, Middle June Denise Wil		·						2. Date of Dea Month Decembe	th Day	Yea	r	3. Time of Death 1306 hrs
		4a. Facility Name (if not institution 25 Pelczar Avenue	n, give street and n	umber)		41	Essex	r Location	of Death		- 1	c. County o		nty
Funeral Director		5. Social Security Number 175 52 0350	6. Sex	7. Age (I	in yrs. last bi	irthday) Yrs.	If Under 1 Ye Months Da	-	er 24Hrs. Min.	8. Date of Bir March			Foreign	nplace (State or Maryland Intry)
th the Maryland 23a or 28a-f show any notified at once.	ecto	Usual Residence of Decedent 10a. State Maryland 10b. County Balt 10e. Street and Number 25 Pelczar Aven	imore	10	c. City, Tow	n or Locatio	n 10f. Žip Code 21 2:	21		1	10g. Ci		10d. Inside City Limits 1 Yes 2 X No zen of What Country?	
fter death wi	by Funeral	11. Marital Status 1 Never Married 2 X M	12. Was De Armed F 1 Yes orced If Yes, Give Ye	orces? 2 X	No No	If Yes	Decedent of Hos, specify Cuba Yes 2 Nos Usual Occup st of working li	ispanic Ori an, Mexican o specify: ation (Give	kind of wo	Rican, etc.)		14. Race White	, etc. Whit	-
5-0036 lied within 72 hours ar Hygiene. I other than "natural the Medical Examin	mpleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		_	ousewi:		use retire	, d		Own H	ome	
21215-0 vuld be filed w Mental Hygi marked othe	Be Co	17. Father's Name (First, Middle, Donald Porter						18.Mother Joann		First, Middle,	Maide	n Surname)		Unk.
ore, MD 21215-003 gs 1 and 2 should be filed withi of Health and Mental Hygiene. If item 27 is marked other ti	2	19a. Informant's Name/Relations Michael Wilson		and)	2	25 Pel	Address (Str CZAI AV	enue			Ма	rylan	d 21	221
Baltimore, permit. Pages I an Department of Hea Important: If ites		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or other place) 20c. Location - City or other place) 20c. Removal from State 20c. Location - City or other place) 20c. Removal from State 20c. Removal from State 20c. Removal from State 20c. Location - City or other place) 20c. Removal from State 20c. Location - City or other place)												Fown, State Maryland
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 23 Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Mary												nd 21221
Physician /Medical Examiner		A. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.										ırt	Approximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as Due to (or as											
cecuted and transit		events resulting in death) Last	d.			27 20	me,g9	2/, 12	-10	1.2 am				
760, Treate be executed by physician and the burial - trans	/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes		of pregnanc		me, go	_			23	3d. Date of	delivery	
	Physician	past 12 months?	I FIA6	nant at tim	ne of death		ideath 3 er (Specify)	Ectopi	c pregnan	cy		Month	D	ay Year
, PO.	<u>a</u>	Part II. Other significant condit Obesity; Diat				ng in the un	derlying cause	given in Pa	art I.					he cause of death? ably 4 🗹 Unknown
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certif thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending pipelety filled in by the funeral director, page 2 should be detached for use as	Completed									1 Yes	osy orm <u>ed</u> ?	p d	rior to co	opsy findings available ompletion of cause of S
lital sician: is certi	8	25. Was case referred to medica examiner?	Hospital:	Inpatient	2 FR#	Outpatient		Other		nly one) Home 5	Docid	tence 6	Other	Sanna
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Division pital or Attendia ours after death.	Certification:	3 Suicide 6 Coul			y - At home,	farm, street	factory, office	building, e	tc, 2	28f. Location (or Town, §		and Numbe	er or Rur	al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exa	hysiclan: To the be miner:On the basis and manner	of examin										
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			ssistant Medic	al Exam	iner 90		timore Stre	et, Baltin	nore, M	D 21223				
Sta Regist	ate rar	31. Date filed (Month, Day, Year)		egistrar's	oignature	back	1							
DHMH 17 Rev 1/20	001				0	RIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PER ME 6933 11/29/12 TRT
State of Maryland 7 Department of Health and Mental Hygiene 2 0 | 2 AMEND #25, PER ME 38388 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Susan Leigh Wilson 08:25 A^M November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Co. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 215-96-7403 Usual Residence of Dece Director 1 □ M 2XXF 45 12/24/1966 Washington, DC 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits must be notified at 28a-f 1 Yes 2 X No Anne Arundel Co. Glen Burnie or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8095 Phirne Road, E. 21061 United States or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 X Married 1 ☐ Yes 2 🏋 No If Yes, Give 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) 2 yrs. Elementary/Secondary (0-12) Accounts Manager Office yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ဂ္ George Perry Karen Lynn King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Mr. James R. Wilson, Sr./Husband 200 Carolina Avenue, Apt F Thomasville, NC 27360 Important: If item 2 any injury or other Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/27/2012 Glen Burnie, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Singleton Funeral & Cremation M01121 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Physician/Medical IF FEMALE: 23h Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No
9 Unknown requires that the death Day Unknown o. Part II. Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? σ, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an un death? certificate l 1 Yes 2 No of Vital Was case referred to medical Place of Death (Check only one) 26. examiner? Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending injury Natural 5 Pending work Division 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 77/1 Quarter Date filed (Month, Day, Year) State Registrar

200

usan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b, PER FH G934 12/07/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month illiams 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death 405 DICE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 1 1 M 2 1 F 8-1944 68 Yrs 27 is marked other then "naturel", or items 23a or 28a-f show treumetic event, its Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ڇ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No end Mental Hygiene. Is marked other then "naturel", Yes. Give Specify: 3/ac 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Indus (Give kind of work done during most of working life. DO NOT use retired)/ rrectiona 1anoi Elementary/Secondary (0-12) College (1-4 or 5+) 1 C/9/ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health end Mental Hitem 27 is marked of ည C551C 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 a liams injury or other 20a. Method of Disposition VAR 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 a
Depertment of I
Important: If ite
eny injury or oth XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore 12/07/2012 Parkwood 21. Signature of Figneral Servi Licensee 22. Name and Address of Facility Vauchn C . Greene Funeral Services York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Canca Immediate Cause (Final disease or condition 100 cell Onset and Death Sona Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours efter deeth.

To the Funerel Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use es the burlel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 NO ဂ္ WOSPICE 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Dualt 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature nd little of certifier 29c. License number 10 rember 29 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMES MO 6701 NOW NOLUM 31. Date filed (Month, Day, Year)
DEC 0 3 2012 32. Registrar' Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Adelle M. Weiss A^{M} 2012 10:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 064-12-9329 Director 1 - M 2 TF 7-30-1920 New York 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Examiner must be notified Montgomery Sandy Spring 1 Yes 2 No ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 238 17340 Quaker Lane 20860 United States within 72 hours after deeth 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc. ō à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗱 No Specify: 3 Widowed 4 Divorced Specify Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) å Artist Art Be 17. Father's Name (First, Middle, Last) 1 end 2 should be flied if Heeith and Mentai H item 27 is merked ot 18. Mother's Name (First, Middle, Maiden Surname) Clifford Nachsatz treumetic Helen Grossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Weiss - Son 6903 Maple Street, NW, Washington, DC 20012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pege 1 ò 1 X Burial 2 Cremation 3 Removal from State Depertment of Importent: If any injury or once. 4 Donation 5 Other (Specify) Temple Emeth Mem. Park 12-5 -2012 Brookline, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam sate hes baen signad by tha ettending physicien and pege 2 should be detached for use es the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 🗆 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 1 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 To the Hospital or Attending Physicien: The lew requires that the deeth owithin 24 hours after daeth.

To the Funeral Director: After this certificate has baen signad by tha etter completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director. P.0. Division of Vital Records,

6,

State Registrar

Medical

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Mota med Georgia AVE. 7904

29c. License numb

29d. Date signed (Month, Day, Year) 12-1-2012

Location (Street and Number or Rural Route Number, City or Town, State)

determined

#304 Olney, Maryland 20832

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examinering and/or investigation in manufacture in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and/or investigation in the cause of examinering and or investigation in the ca

2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 1, 2012 Weber 3:23 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 2466 Ellis Road Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days 136-26-5189 77 **Director** 1 □ M 2 X F Merch 15, 1935 New Jersev 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Exeminar must be notified MD Baltimore Parkville 1 Tes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2466 Ellis Road 21234 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Theodore Alexander Alice Robert Hazel Deavor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Butcher-daughter 3733 Bay Drive, Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/4/12 Parkville, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. <u> 1050 York Rd.. Towson. MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mctastatic Dreast Cancel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, After this certificate has been significate has been significated funeral director, page 2 should I 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: Certificate: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier don Mules, MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Philadelphia Rd State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM M Donald R. Wallesz 2012 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville <u>Montgomery</u> Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Director 1 ₹ M 2 □ F 397-18-0649 Yrs 87 July 27, 1925 Wisconsin Usual Residence of Decede 3e or 28a-f show be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 📮 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Pege 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e any injury or other treumatic event, the Medical Evarniner must b 1775 Redgate Farms Court 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Š 1 ☐ Yes 2 🔯 No Specify: white 3 Widowed 4 Divorced Specify: Completed '43-46 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Arthur Wallesz Gladys Rusch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wallesz/spouse 1775 Redgate Farms Court Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Foreral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ardiac Medical Due to (or as a consequence of): Examiner ronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ettending physician and I for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the etter page 2 should be detached for in the past 12 months? Month Dav Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The performed? 1 Yes 2 No Yes 2 No or Attending Physicien: Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 SER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funerel D completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0062435

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records.

Division of Vital

Molecular Drive Svite201. Rockville ND 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

0110

Say

31. Date filed (Month, Day, Year)

NFC 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear **Physician** Winder 27, luanita 0637 November 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 73 218-36-7344 JULY 7, 1939 MD Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Yes 2 No Director TURNER STATION BALTIMORE MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21222 406 CHESTNUT CT. Funeral ıral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status should be filed within 72 hours after ond Mental Hygiene. marked other than "natural", or ite 1 ☐ Yes If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: BLACK þ 3 Widowed 4 Divorced er than "natural", the Medical Exan Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY BETHLEHEM STEEL permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important; if item 27 is marked any injury or other Proces. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILEY DEAN BEATRICE CHRISTIAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA WINDER/DAUGHTER 406 CHESTNUT CT. BALTIMORE, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **METRO CREMATORY** 12-1-2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Caronary Vascular Dizease rears Atherosclerotuc disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy atten ò in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) page 2 should be detached 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 TYes Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 1 ☐ Yes 2 No 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗆 Inpatient 2 X ER/Outpatient 3 □ DOA 2 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural (Month, Day 5 Pending investigation Injury 1 🗌 Yes 2 Accident 2 🗆 No 3 ☐ Suicide 6 ☐ Could not be

death certificate be executed Box 68760. P.O. of Vital Records,

death v

Baltimore, Maryland 21215-0036

Division or Attending death. after death 24 hours Hospital

Medical

Edward 31. Date filed (Month, Day, Year) State Registrar

bestman 32. Registrar's Signature 00028684

1 (Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 27, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 ☐ Homicide

(check only

29b. Signature and title of certifier

DEC 0 3 2012

29a. Certifier

one

4940 Eastern Avenue, Baltimore, MD, 21224

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

00028684

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEPHEN M. ZEMANEK NOVEMBER 2012 8:15 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min Director 173-36-2045 1 X M 2 □ F 11/7/1945 67 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE MD LUTHERVILLE-TIMONIUM 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 239 205 BELMONT FOREST COURT UNIT 102 21093 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ō 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) VICE PRESIDENT OF SALES SHEET METAL **YEARS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 Department of Health and Menta Importent: If item 27 is marked eny injury or other traumation မ STEPHEN F. ZEMANEK MARGARET MULICKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) ROSEMARY E. ZEMANEK/WIFE 205 BELMONT FOREST CT., UNIT 102 LUTHERVILLE-TIMONIUM 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOVEMBER 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State BETHLEHEM-STELTZ REF. 4 ☐ Donation 5 ☐ Other (Specify) 12/3/2012 GLEN ROCK, PA CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 STEPHEN ZEMANEK IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Hospital or Attending Physician: The law requires that the death in the past 12 months? 5 Other (specify) Day Month Yea ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 🗌 No 1 Yes director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕱 No Other: $_4$ \square Nursing Home $_5$ \square Residence $_6$ \square Other (Specify) \blacksquare HOSPICE ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director: After this
completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 🗌 No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar

29b. Signature and title of contifie

JACKIE JONES,

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRMP

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

			For State Registrar		State	of Maryl		artment of F rtificate of		Mental Hy	giene Reg. No.	2012	38895	
	Physici	an	1. Decedent's Nam	ne (First, Middle, Virginia						2. Date of De Month	eath Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (number)		4b. City, Town, o	or Location of Deat	11 h	12 4c.	2012 County of Deat	21:23 M	
اعلی منتقات			100 Hone 5. Social Security N	•	Lane	7 Ago //p	um last hirthday	Frostl	ourg	8. Date of Bi	rth	Allega	any hplace (State or Foreign	
	Funeral Director		220-30-85		1 M 2 N 1		yrs. last birthday) Yrs.	Months Days	Hours Min.		ay, Year)	Go Co	white (State of Foreign	
ï	w t		Usual Residence o	f Decedent 10b. County		100	. City, Town or Lo	ocation					10d. Inside City Limits	
	Maryl a-f sho	ţoţ	MD	Alleg	any		Frostb	urg					1 XYes 2 No	
	or 28s	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citiz	zen of What Co	untry?	
	eath w	Funeral	100 Hone	eysuckle		ecedent Ever	in II S 13	21532 Was Decedent of F		Specify Yes or N	n- ·	USA 14. Race - Ame	rican Indian,	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amplying the 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Mari 3 ☑ Widowed	ried 2□ Marrie 4□Divorced	Armed 1 🗀 Ye If Yes,	iForces? es 2. ☑ No		If Yes, specify Cub	Specify:	to Rican, etc.)		Black, White, etc. Specify: White		
ה ה	72 ho 'natur	eted	(Spe	15. Decedent's cify only highest	s Education t grade complete	ed)	1 (Give	dent's Usual Occup	during most of wo	rking	16b. Kir	nd of Business/	Industry	
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alla	al Hyg	Be C	17. Father's Name	(First, Middle, L	.ast)				18. Mother's Na	me (First, Middle	e, Maiden	Surname)		
Z	d Ment d Ment narkec	ု	Woodr	ow A. J			10h Maili	ng Address (Street		ryn Can		r Town State	Zin Cada)	
Ma	nd 2 sl atth an 27 is r r traur		Jeff Auv		ip (<i>type. Ffilit)</i>			Pond Ci						
ָרָ בּי	of Hear		20a. Method of Dis		3 □ Removal fr	om State		osition (Name of matory or other pla	>	Date 16/2012	20c. Lo	cation - City or		
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0	permi Depar Impor any ir		21, Signature of F	uneral Service L	densee	17/19		urdock-Fi I N 2nd		Tuneral	H956	P.A.		
Ē			23a. Part1. Enter shock, or hea	the disease, or cart failure. List o	complications th	at caused the		ter the mode of dyi					Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a			whic V	melure	disus	1		y V S	
-	Examiner		,		Due	to (or as a cor	nsequence of):							
	p #	iner	Sequentially list concause. Enter Under Cause (Disease or	onditions, missilate erlying	D. Ous	to (or as a col	зведиенов от):							
9	xecute and al-trans	Examiner	that initiated event resulting in death)	S	c	to (or as a cor	nsequence of):							
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oo x	ertifica ding ph	O I	IF FEMALE:		220 If you	outcome pf pr	ognopeu.	-						
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'n	ss that gned b	by Pt	Part II. Other signi	ificant condition	ns contributing t	o death but no	t resulting in the u	ınderlying cause gi	ven in Part I.				the cause of death?	
cords,	requir		17N	171	A] Yes 2[robably 4 Unknown	
שבו וג	: The law cate has b	Completed								24a. Wa auto per 1⊡ Yes	s an opsy formed? 2 V No	24b. Were all prior to death?	utopsy findings available completion of cause of 2 □ No	
7	s certifi	o Be	25. Was case refe examiner? 1 Yes 2 □		Hospital: 1	☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Ot	26. Place of De her: 4 ☐ Nursing	eath (Check only		6 □Other (Spe	acifu)	
5	ng Phy ter this neral d	n: To	27. Manner of Dea		28a. D	ate of Injury Month, Day Yea	28b. Time o	0	- Itarang	28d. Describe			scny)	
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5	al or A	Certification:	4 ☐ Homicide	determin	ned 200. Fi	uilding, etc. (S)	pecify)	reet, factory, office			own, State		urai noute Number,	
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Ulrector After this certificate has completely filled in by the funeral director, page 2 seconditions.	edical C	29a. Certifier (Check only one)		examiner: On the			th occurred at the t nvestigation, in my						
	To the withing to the complex	Me	29b. Signature and	title of certifier	12			29c. Licen			29d. Da	te signed (Mon		
			30. Name and add	lress of person w	vho completed	Zause of death	(Item 23a) (Type		515		- 11	113/1	2	
		1	Rabie	Za1Za1	, MD 5	37 S Mi	ineral S	t., Keyse	er, WV 2	6726				
	Sta Registr		31. Date filed (Mor	NOV 15	2012	2. Pegistrar's S	Signature	ares						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November Day Physician/ 1046 PM Bonita Jane BRANNON 17,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 215-42-3699 Director 68 Maryland July 9,1944 rral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firem 27 is marked other than "natural", or items on other trainments. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 Fernwood Lane 21740 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by white 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) credit card customer service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Jane Blenard မ Harry Lowe Powers, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Brannon - husband 9715 Fernwood Lane, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home rolut () 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Lung disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injurithat initiated events resulting in death) Last use as the burial-tran the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 041667 11.19.12

Registrar

31. Date filed (Mo.

Carpes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

neck

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P Physician/ Anna Maria BRYAN 7:50 M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 213-46-8497 1 M 2 X F 88 March 14,1924 Germany permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Dapartment of Health and Mantal Hygiana.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any, joury or other traumette event, the MacKeal Examination 200. 10c. City. Town or Location 10d. Inside City Limits Director Williamsport Maryland Washington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 U.S.A. 16505 Virginia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married white 1 ☐ Yes 2 X No Specify. 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation V.A. Administration (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pfisterer Schneider Frieda Franz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 South George Mason Dr., Apt 202 Falls Church, Carter Bryan - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory November 2012 cemetery, crematory or other place, Hagerstown, Maryland 4 Donation 5 Other (Specify) Minnich Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Itali-415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Swall Immediate Cause (Final Onset and Death Physician/ asstruction disease or condition Medical resulting in death) Due to (or as a consequence of): _ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) signed by the attending physicien and id ba datachad for use as the buriel-transit Hospitel or Attending Physician: The law raquiras that tha daath cartificate be axecuted that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thullaten 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performe this cartificata 1 ☐ Yes 2 ☐ No Yes 2 4 ours after death.

erel Director: After this cartifica filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\bigcap \) Nursing Home 5 \(\bigcap \) Residence 6 \(\bigcap \) Other (Specify) 1 Tes 2 - HO 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospitel within 24 hours a To the Funerel L Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier complataly Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2006 1117

State Registrar Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAN CISCO

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vovember 16 2012 2000 M Brian David Beam Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 2,1964 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 213-90-4004 Hours Mary Land 48 Director 1 X M 2 □ F Usual Residence of Deceden th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 Alexander St. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceden 2... Armed Forces? 1 ☐ Yes 2 💢 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Tulis Beam Grace Irene Freeland permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Carling Circle Halethorpe, MD 21227 Jack R. Beam-brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory 11-21-2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the dise set, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 9 Unknown 2 No been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy completely filled in by the funeral director, 25. Was case referred to medica Be 6. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No မှ 1 Inpatient 2 I ER/Outpate/it 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 2 🗌 No ☐ Accident Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDEROLL 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl Time of Death -29AM Physician/ RINNS GARE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Atria Manresa Anne Arundel Annapolis 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 235-12-1571 98 Director 1 M 2 D 5/30/1914 Yrs WV Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 Yes XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 85 Manresa RD. 21409 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XXXIo White Specify: Completed 3XXWidowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lowe Ella Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20732 <u>Gabrielle Carsala Grandaughter</u> 7146 Chesapeake Village Dr. Chesapeake Beach, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Elmwood Cemetery 11/13/2012 Shepherdstown, WV 21. Signature of Furreral Service Licensee 22. Name and Address of Facilit Hardesty Funeral Home, P.A. a 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Iπterval Betwe Immediate Cause (Final Physician/ N disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) æ 1 🗌 Yes Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 Yes Investigation 6 Could not be 2 🗌 No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 118 2012 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 DEFENSE HWY, ANNAPOLIS M.D. 2140 Ylor JENEVIEVE

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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- 6	Examir	er	4a. Facility Name (if not institution, give sti			4b. City, Town, or	Location o	of Death		- 1	c. County of Dea	
Sec.	Funeral		St. Mary's Hospit 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Leonard If Under 1 Year	town If Under:	24 Hrs. 8	Date of Birt		t. Mary	Thplace (State or Foreign
40	Director			M 2 🗓 F	Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)	Co	ountry)
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	or 28	Dir	10e. Street and Number	s Lex	ington	10f. Zip Code				10g. Ci	itizen of What C	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	46860 Hilton Drive	, Apt. 2913		20653				Uni	ted Sta	tes
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Maryland	should and N is ma		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street a	nd Numbe	r or Rural Ro	ute Numbe	r, City o	r Town, State, Zi	ip Code)
ō.	and 2 Health em 27 ther t r		Catherine Gardner/			Drayden	Road				20630	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 XBurial 2 Cremation 3 Re	emoval from State		atory or other place	· .	Date			ocation - City or	
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√ \ 760	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director. After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d.									
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Вох	he att	/sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)	9				Month	Day Year
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	Within To the CO The CO		29b. Signature and title of certifier	-		29c. License					te signed (Monti	
			Vatricia (jurny, 1	ND	D20	034	4	/	VO	UEMBE	ER 13 2012
(a)				leted cause of death (Iter	n 23a) (Type, Pr	int)	Haco	ر المسام ا				MARYLAND
	Stat	e	ATRICIA GURNY 181. Date filed (Month, Day, Year)	32. Registrar's Signa	nture	MARYS	PUSP	1146	heo	IU ITI	KUIUWA	- ITITKY LAWI
	Registra		NOV 2 0 20	32. Registrar's Signa	B. A.	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine E. Bethel 10 2012 10:07A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) 82 578-42-3963 Director 1 M 2 4F 01/29/1930 Washington,DC 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 28a-f 1 X Yes 2 No Silver Spring MD Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **2**3a Funeral 20904 USA 12605 Billington Road items 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter dical Examiner Black, White, etc. Completed by Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

The strict of Transacked other than "natural", or any file traumatic event, the Medical Examilury or other traumatic event, the Medical Examilury. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. **Black** Specify 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Kenwood Golf and is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Country Club ĩĩ Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Johnson Frank Lynch, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everett Lucas, Jr./Son Tola Court Hyattsville, Maryland Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Memorial Park 11/10/2012 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th Street, N.W. Washington, D.C. art 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Diabetes Medical Due to (or as a consequence of): **Examiner** Parkinson's Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): as the burial attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death 1 Yes 2 X the detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? Yes 2X No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 Xio Be 26. Place of Death (Check only one) Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify 1 XInpatient 2 🗆 ER/Outpatient this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred After injury 1 XNatural 5 Pending М Accident Investigation To the Hospital or Attency within 24 hours after death To the Funeral Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and little of

30. Name and address of person who completed cause

Husna R. Baksh, M.D.

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012

death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0043436

10801 Lockwood Dr. Suite 280 Silver Spring, MD 20901

29d. Date signed (Month, Day, Year)

11/08/2012

Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 3890 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Charles E. Brown 4:15 P 2012 Medical Nov 7. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs, last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 081 32 9229 1 🕅 M 2 🗆 F 69 Nov 28, 1942 Mississippi 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 3228 Burton Court 20748 United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 V Yes 2 □ No If Yes, Give 1957–1978 Year or Dates ģ 1 Never Married 2 v Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Air Force U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 2 Anna McClender Shelly Brown Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Importent: If item 27 is any injury or other trau Doloris M. Brown (Wife) 3228 Burton Court, Temple Hills, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State lington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria orus *mooas1* Ferry Road, Clinton, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final PSIS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMON ARY CHRONIC OBSTRUCTIVE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an HYPERCOAGULABLE STATE 2 200 1 Yes Hospitel or Attending Physicien: 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ê 2.23No 1 Tes 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Within 2 To the F only one and title of certifier 29b. Signature 8/2012 28281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLINTON, MD 20735 ROAD, BENJERS, 9131 PISCAT MWAY

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Mor

parker

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

aldrew 5. boyce		State of Maryland / Department of Health and Certificate of Death	i Wentai n		g. No. 201	2 3890
Physicia Medical Examir		Decedent's Name (First, Middle,Last) ANDREW JOSEPH BOYCE		Date of Deat Month November		3. Time of Death 1915 hrs
Service .		4a. Facility Name (if not institution, give street and number) Atlantic General Hospital Berlin	ocation of Death		4c. County of Deat	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		→	h(MM/DD/YYYY) 9. Bir	
Director		358-17-5432 1X M 2 F Yrs. 5 Amonths Days Usual Residence of Decedent	Hours Min	06/16/		puntry)DELAWARE
# aoy		10a. State 10b. County 10c. City, Town or Location		<u></u>		10d. Inside City Limits
Maryland 28a-f show	ģ	DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code		110	g. Citizen of What Cou	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at 00cc.	Director	32293 TRANQUILITY LANE 199	945		US	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene iem 27 is marked other than "ostural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at ooce	unera	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No			14. Race - Amer White, etc.	ican Indian, Bleck,
s after d ral", or	Ų L	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No				HITE
72 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life.			16b. Kind of Business/	Industry
5-0036 led within 7/ Hygiene other than	Completed	N/A N/A 17. Father's Name (First, Middle, Last)	8 Mothor's Name	e (First, Middle, N	N/A	
21215-0036 hould be filed within 72 and Mental Hygiene is marked other than it ervent, the Medical	Be	BRIAN K. BOYCE, JR.	CRYST	AL ANN	HEWETT	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Importact: If item 27 is ma injury or other traumatic or	۵	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street BRIAN K. BOYCE, JR/FATHER 32293 TRANQUII				
ore, National Street	Ì	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cem	netery,	Date	20c. Location - City or	Town, State
Baltimore, Department of He Important: I ite		4 Donation 5 Other Specify: MELSON'S CREMATOR		30-12		, DELAWARE
Bas Derm Inp		MELSON FUND 43 THATCHER	ERAL'SER R ST, FR	VICES, 1	LTD. , DE. 19945	
Physician Medical		23a. Part I. Enter 1 to disease, or complications that caused the death. Do not enter the mode of dying, s failure. List 1 ly one cause on each line.	such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Caute (Final disease or condition resulting in death) a. ASPNYX1.a Due to (or as a consequence of):			<u> </u>	
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
T 15	Exami	(C)isease or injury that initiated events resulting in death) Last Une to (or as a consequence of):				
execui in and il - tra		d. AMENDED 23a,27,28a-f,per me,g93	6 2-13-	13 sm		
Box 68760, e death certificate be exe the attending physician a ed for use as the burial -	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
ox 68 th certif ttending or use as	Physician/	past 12 months? Pregnant at time of death Other (Specify)	Ectopic pregna	ancy	Month	Day Year
b.O. Bc that the deaned by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P.O. uires that the signed by d be detach	д 2				2 ✓ No 3 Pro	bably 4 Unknown
cord: law requested has been	Completed			24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical 26.Place of the control of the co	of Death (Check	1 ✓ Yes 2	2 No 1 🗸 Y	es 2 No
Physician this central direction	Lo Be	Tes 2 No			Residence 6 Othe	r,
Sion of Attending Pt death. ector: After y the funeral		1 Natural 5 Pending (Month, Day, Year)	yat Work? es 2 🗶 No		was found	wedged with
Division or Att ours after de ceral Directe filled in by 1	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office but	ilding, etc.	28f. Location (S or Town, St	treet and Number or Ruate) 33205 Mod	ural Route Number, City
		4 Homicide (Specify) Mobile Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date of the control of the	te and place, and	Dagsbor	O,DE	
To the Hos within 24 h To the Fuo completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated. 29b. Signature and title of certifier 29c. License		at the time, date a		
	<	Proposition of the original of the original of the original of the original of the original of the original of the original of the original of the original			29d. Date signed (Mo	
	-	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD. Assistant Medical Evaminer, 200 W. Baltimore	Street Date	more MD 24	223	
Sta	te	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature	orreet, Baiti	more, MD 21		
Registr		NOV 2. 6 2012 James A. Barker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 127 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL PONINSMLA MADICAL Cento SALISHIL HICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 217-12-497 Days Director 1 **X**M 2 □ F -10-1925 28a-f shov 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No ccamacis hincoteaque 10e. Street and Number 10f. Zij Code 10g. Citizen of What Country? Funeral 4428 23336 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give "natural" 3 Widowed 4 Divorced Year or Dates. 1943-1944 Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other trai hineoteague Bunting 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 a Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department o Important: If any injury or Quantico 4 ☐ Donation 5 ☐ Other (Specify) 31-2012 riangle National Cem. 21. Signature of Funeral Service Licensee hincoteague, up 23336 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) SC Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 9 Unknown ate has been signed by the a page 2 should be detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 X To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the Dicertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (olling Gerald 1505 11 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Baltimore University Marriand Conte If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 217-80-9463 52 Hours Director 1 X M 2 □ F 1960 Delaware Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Queen Anne's Millington MD 10f. Zip Code 10g. Citizen of What Country? Funeral 125 Archer Lane 21651 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes If Yes, Give White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Residential Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter's Helper Construction 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence A. Collins, Jr. Ethel E. Traverse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Archer Lane Millington, MD. 21651 Lawrence A. Collins, Jr. (father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Townsend Cemetery 1 X Burial 2 Cremation 3 Removal from State 11/17/12 Townsend, DE. 4 Donation 5 Other (Specify) Fine al Serv 2. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ UGI Bleed disease or condition Medical resulting in death) Examiner Microscopi C Sague fially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic steroids 1 Yes 2 No 3 Probably 4 Unknown Disseminated fungal infection 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: 유 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 25726 10,2012 NOV

Registrar DHMH 17 Rev 06-2011

State

Ms

John

Baltimore

MD

21201

St.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Fied	se type or i								egible	•
		For State	State of	Maryland	•	rtment of		and I	vlental Hy	giene	012	38906
		Registrar			Cer	tificate of	Death			Reg. No.	C/ 1 6-	0000
Physicia	n/	Decedent's Name (First, Middle	Last)			2	,		2. Date of Dea	ath Day	Year	3. Time of Death
Medic		WILL	-IAM	\mathcal{A}		OLEM	AN		NOVEMB	ER 9	2010	20925 M
Examin	er	4a. Facility Name (if not institution,	give street and numb	er)		4b. City, Town,	or Location	of Death		4c. Cou	inty of Dea	th
			ER HOSP		ENTA	R CH	+ F 51	EB	TOWN		KEN	VT
Funeral		5. Social Security Number		. Age (In yrs. las:	t birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da)	h v, Year)		thplace (State or Foreign
Director		218-16-7417 Usual Residence of Decedent	1 X M 2 □ F	9	86 Yrs.				06/18/1	926	MAR	YLAND
show dat	-	10a. State 10b. County			Town or Loc	ation			00/10/1	. , 20	IIII	10d. Inside City Limits
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he Mi or 28 e noti	Ē	MD KENT 10e. Street and Number		WORT	JN	10f. Zip Code				10g. Citizen	of What Co	
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ath w	Funeral Director	10670 WORTON RO	12. Was Decede	P.O. BO		as Decedent of	Hispanic Ori	ain? (Sne	ocify Yes or No-	UNITE		TES erican Indian,
or ite	by F	1 Never Married 2 X Marr	Armed Forc	es?	lf.	Yes, specify Cub	an, Mexicar	1, Puerto	Rican, etc.)		Black, Whit	
s after ral",		3 Widowed 4 Divorced	If Yes, Give	s 1946–4	/ Q 1	Yes 2 X N	o Specify:			Spe	cify: WHI	тг
hour natu	Completed	15. Deceder	t's Education	1940	16a. Decede	ent's Usual Occu	pation			16b. Kind o		
n 72 s. an " _l Mec	티	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)		ind of work done NOT use retired		t of work	ing			ŕ
withi giene er th , the		11	Jonege (,	SUPERI	NTENDAN	T OF M	1AIN	FENANCE	COLLE	GE	
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, L	ast)				18. Moth	er's Nam	e (First, Middle,	Maiden Surn	ame)	
d be Menta arked itic e	의	WILLIAM ARTHUR	COLEMAN				BERN	CE S	SCHAUBEI	₹		
2 should be filed within 72 hours after death with the the and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be traumatic event.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	g Address (Stree	t and Numbe	er or Rura	al Route Numbe	r, City or Tow	n, State, Zi	p Code)
nd 2 sealth n 27 er tra		BETTY ANN COLEM	MAN / WIFE		P.O.	BOX 175	WORTO	ON, 1	MARYLANI	2167	8	
of He		20a. Method of Disposition 1 X Burial 2 Cremation	0		ce of Dispos	sition (Name of atory or other pla	ace)		Date	20c. Locati	on - City or	Town, State
permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra		4 Donation 5 Other (S		iaic 1		EMETERY		1/1	5/2012	CHEST	ERTOW	N, MARYLAND
permit. Departr Importa any inji		21. Signature of Funeral Service L	censee		22.	Name and Addr	ess of Facili	tv				
		Kut S	Ney	$\mathcal{C}(\cdot)$		LLOWS, O SPEER	ROAD	CHE	N & NEWI STERTOWN	NAM FUI	NEKAL YLAND	HOME, P.A. 21620
1000		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complic tions at car	used the death.	Do not ente	the mode of dy	ng, such as	cardiac d	or respiratory arr	est,		Approximate
Physician/		Immediate Cause (Final	ily one Section each	2.7 %	ofic	Sho	ck				- 0	Interval Between Onset and Death
Medical		disease or condition resulting in death)	a. Due to (or	as a consequer		3,10					_	
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tificat ng ph as th	Me	IF FEMALE:	T									
endii	a	23b. Was decedent pregnant	23c. If yes, outco	me of pregnance rth 2 - Fetal c		Ectopic pregnar	ncv			23d.	Date of de	livery
deatl	Sici	in the past 12 months?		int at time of dea		Other (specify)					Month	Day Year
t the	Physician/Medi	9 Unknown							Ť			
gned be de	ρ	Part II. Other significant conditio	-		-		iven in Part	I.				the cause of death?
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aw re as be	ᇍ	Dia	Bules						24a. Was a			topsy findings available completion of cause of
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hysic his ce il dire	욛	1 ☐ Yes 2 🕱 No	Hospital:	patient 2 🗆 EF	R/Outpatient	3 □ DOA Ot	her: 4 🗌 Nu	ursing Ho	ome 5 🗆 Resid	ence 6 🗆 (Other (Spec	cify)
ng P fter ti	<u>i</u> ë	27. Manner of Death1 ☑ Natural5 ☐ Pending	28a. Date of (Month,	injury 28 Day, Year) 28	8b. Time of injury	28c. Inju woi			28d. Describe h	ow injury occ	curred	
endi eath. or: A the fu	<u>≅</u>	2 Accident Investig	ation		_		Yes 2	No				
r Att fter d irect n by	Certificate:	4 Homicide determi	28e. Place of	Injury - At home, etc. (Specify)	e, farm, stree	et, factory, office			28f. Location (S City or Tow		mber or Ru	ral Route Number,
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Hosp 24 ho Fune tely f	Medical	(Check 2 Medical E		of examination a	nd/or investig	gation, in my opin	ion, death or	curred at	t the time, date a	nd place, and	due to the	cause(s) and manner stated.
the the the mple.		only one) 3 Certifying	Nurse Practitioner: T			death occurred at	the time, da		ace, and due to t	ne cause(s) ar	nd manner a	as stated.
5 × V × V		29b. Signature and title of certifier	1 -	MI	\	29c. Licens		יסכז פ		29d. Date sig	ned (Monti	h, Day, Year)
15) 4.4.				707			///	09	1 1012
+		30. Name and address of person v			3a) (Type, Pr	int)	,	, ~	Ĵ.	(heste	- 14:	w MA
2		GONZUO 31. Date filed (Month, Day, Year)		(0(00 13	NOWA	1 -	7 •	C M(S)(11000	JPJ TO
State Registra	_	PAN 1	3 2012 b	is ar's Signatur		MARKET						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Phippin Cooper Dorothy **Medical** 4a Facility Name (if not institution, give street and number Examiner or Location of Death 4c. County of Death SOLL Year If Under 24 Hrs. **Funeral** Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) 214-10-7054 **Director** 1 🗆 M 2 🕱 F 99 07/23/1913 Maryland 28a-f shov items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1110 Healthway Drive 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Pearl Culver Jerome Garner Phippin Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4074 St. Lukes Rd., Salisbury, MD 21804 Judith C. Adkins/Daughter Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/24/2012 Salisbury, MD 21 Signatur of Fun, al Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association Dompor 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) the Hospital or Attending Physician: The law requires that the death Dav Year Pregnant at time of death 9 Unknown g Unknown rate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ! 1 ☐ Yes 😢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ျှ 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 4-C Certificate: 28d. Describe how injury occurred at Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and litle of certifie 29c. License number 1 63 199 Name and address of person who completed cause of death (Item 23a) (Type, Print) OGESIA VOHRA 910 EASTERN SHOLE DR, SALISBURY, MD, 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Callowan 14120 160 10 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Baltimore, of Maryland House to altimore **Funeral** If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreig Country) 150-34-6079 **Director** 1 🗆 M 2 🕱 F 68 09/14/1944 Delaware with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified Worcester Berlin Maryland 1 Yes 2 X No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8433 Logtown Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Completed by Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Marie Hopkins ပ Ronald Bacon Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8433 Logtown Rd., Berlin, MD 21811 Edgar C. Calloway/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/24/2012 Salisbury, MD Wicomico Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has performed? Yes 2 No 2 🗌 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Contifying Nerse Practitioners To the best of my knowledge, death occurred at the time, date and place, and 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1215195662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomere Thomas Klew

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Year)

32. Begist a s Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMENID#10f, 19a per_State of Maryland / Department of Health and Mental Hygiene State 11/20/2012 AAHE FH CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patrick William Clouse November 10, 2012 4:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Somerford Place Columbia Howard Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) November 2,1921 Months Days Hours Director 286**-**18-8288 1**X** M 2 □ F 91 Ohio or than "natural", or items 23e or 28e-f show the Medical Evarriner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Laurel 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 350 Marganza South 20704 20724 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ğ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: specify: White 3 N Widowed 4 Divorced Completed Year or Dates. 40 - 62 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) U.S. Army/ NSA College (1-4 or 5+) Communications Chief 1 and 2 should be filed wir of Health and Mental Hygie item 27 is marked other other treumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ketty Fiedier/ Daughter 17 S. Prospect Avenue Baltimore, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it eny injury or o 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Huntt Crematory 11/13/2012 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician Onset and Death Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and Id be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) **P** Other: 4 Nursing Home 5 Residence 6X Other (Specify) ASST 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this Livin 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending injury work?
1 Yes 2 No s after death.

I Director: All in by the fu Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Heepital or within 24 hours at To the Funeral Di Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person with completed cause of death (item 23a) (Type, Print) Lazris. 6334 Cedar Lane #103 MD Andre Columbia, MD 21044

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Gretchen Williamson Carlquist 1:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 Spindrift Way Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday Hours Director 338-38-5900 1 🗆 M 2 🕱 F 67 7/22/1945 Oklahoma 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🕱 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Spindrift Way USA 21403 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Analyst Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ပ Elmer Carlquist Marjorie Williamson and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Krista Hunter / Daughter 906 Lantern Tree Ln., Wellington, FL 33414 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2012 Edgewater, MD 21. Signature of Eurieral/Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Par 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Strust Cancer 40015 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perforn death? certificate Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ပ 4 🗆 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 5 Pending Natural 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis or examination and or investigation, in this optimize, documents, and due to 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1203 Medical Parking #210, Amapolis, MD 21401 werne State

Registrar

P.O.

Records.

Division of Vital

State Registrar Elizmseth

31. Date filed (Month, Day, Year)

21412

Great Mills Road, Lexington Park, MD

(PNP

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 0320 ames Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours Director 231-86-8676 1 □XM 2 □ F 55 Yrs 02/26/1957 Alexandria, VA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner manner. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 H No Waldorf MD Charles 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 15051 Truman Manor Lane 20601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4 or 5+) Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James C. Cook Deloris A. (Sansbury) Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deloris A. Johnson / Mother 15051 Truman Manor Lane, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem 11/18/2012 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., Signature of Funeral Service Light #M01458 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ntracran disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Due to (or as a consequence of): eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MSION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural
2 ☐ Accident
3 ☐ Suicide 5 Pending injury death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours aff To the Funeral Discompletely filled or Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year 29c. License number 12 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3, 2012 Juniper Capece 3:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 140-24-2532 Hours (Month, Day, Year) 80 1 🛚 M 2 🗆 F **Director** April 14, 1932 Usual Residence of Decedent fshow 10a. State Fage 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes 2 X No MD Montgomery Silver Spring ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1650 St. Camillus Drive 20903 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married "natural", or 1 ☐ Yes 2基 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Tailor Religious Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincenzo Capece Arminda Romano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Fage 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Tom Conway/Religious Superior 1650 St. Camillus Drive, Silver Spring, MD 20903 20b. Place of Disposition (Name of cometery, crematory or other place)
Holy Sepulchre 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 📭 Removal from State 10, 4 ☐ Donation 5 ☐ Other (Specify) Totowa, NJ Cemeterv 21. Signature of Funeral Service Licensee

Som Fyle Cally M44 Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Hepato cell disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ending physician and use as the burial trans that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Cother (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor: After this certificate has been signed the funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending work 1 \sum Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, auun3 050987 11-7-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAWAZ MD. 1500 forest glen and silver spring 31. Date filed (Month, Day, Year) State NOV 09 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Manuel A. Collaso aM 201 Vovember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months **Director** 450 28 2610 1 XM 2 - F 94 Oct 11, 1918 Texas "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland 1 4 1 Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 2392 Ironwood Drive 20601 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: WITT Specify: 3XX Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) USAF Photographer U.S. Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ventura Collaso Jessie (unk) ge 1 and 2 should b it of Health and Mer If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Collaso (Son) 2392 Ironwood Drive, Waldorf, MD 20601 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 11-19-2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licens Ferry Road, Clinton, MD 20735 23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, swock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death u moma Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 as IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death Month Year 9 Unknown signed by ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Yes Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending after death. 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signati 30. Name and address of Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Beulah L. Core 0315A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death KLAIDHAL MEGICOL TEHINSULD SAU/SONI HICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Days 220-01-7370 Hours Director 1 M 2 X F Yrs 90 08/02/1922 Maryland Usual Residence of Decedent "neturel", or Items 23e or 28e-f show adical Examiner must be notified at 10a, State 10c. City. Town or Location within 72 hours efter death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Salisbury Maryland Wicomico 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 30301 Zion Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Manufacturing Seamstress Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health end Mental Hy Importent: If Item 27 Is marked otheny Injury or other treumetic event 18. Mother's Name (First, Middle, Maiden Surname) Ida Mae Burke Elwood E. Beauchamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Day/Daughter Zion Rd., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Springhill Memory Cardens 11/14/2012 Hebron, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition sequence of): Medical resulting in death) Due to (or as a c Examiner 716 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlel-transit Hospitel or Attending Physicien: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UTC

Registrar

State

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egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2012

HEOIN

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claude Leroy November 07 2012 2:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot 29411 Petunia Drive Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) Director 238-28-3842 1 X M 2 D F 89 06/16/1923 South Carolina Usual Residence of Deced Director 10a, State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29411 Petunia Drive 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 x Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 1941-46 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Developer Housing 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ McCoy Logan Dixon Emma Ellen Byers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine R. Dixon/ Wife 29411 Petunia Drive, Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Paga 1 a
Department of H
important: if ite
eny injury or ott 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 🗋 Donation 5 🗋 Other (Specify) Maryland Veterans Cemetery 11-15-2012 Crownsville, Maryland 21. Signature of Emeral 5 ervice I 22. Name and Address of Facility George P. Kalas Funeral Home <u> 2973 Solomons Island Road, Edgewater, </u> MD 21037 23a. Part 1. Entity the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final CAVDIOMON Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ettanding physician end i for usa es tha burial-trensit Hospital or Attending Physician: The law raquires that the daeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death baan signed by the e should ba datached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes aftar death.

Director: Aftar this certificad In by the funarel director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my policies. In the cause of the cause 29a. Certifier complately (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51132 November 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

NOV 1

Jorge Horacio Abrego-Garcia, 598 Cynwood Drive, Suite 104, Faston, Maryland 21601

Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 : 10a Physician/ Lourdes Del Rosario Salamanca De Martinez Mrov.5,2012 Medical 4a. Facility Name (If not Institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Montgomery 16512 Walnut Hill Road Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 213-33-9464 1 M 2X Days Hours Min. 3/31/1963 ^{Country)} Salvador **Director** 49 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral El Salvador 20877 16512 Walnut Hill Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Fl Salvadoran Maryland 21215-0036 White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Housekeeper 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Angelica Salamanca Jose Luis Canas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20877Rigoberto Martinez/Husband 16512 Walnut Hill Road Gaithersburg, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 😾 Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place San Miguel, El Salvador 11/12/2012 General Cemetery Signature Funeral Service L PAINTY ADERINALDI FUNERAL SERVICE, P.A. malo Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 2 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to lor as a consequence on attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check iqation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar DHMH 17 Rev 7/2009

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State

Signature and title of

Name and address of pers

certifie

n who completed cause of death (Hem

41)

2. Registrar's Signature

Tun

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29d. Date signed (Month, Day, Year)

731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar					Certific	ate of	Death					Reg. No.				
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Pay Yes												Voor		3. Time of De		
edical Exami	iner	Kenneth	Mayo	Dav	is								Novemb	er 22, 2	2012		1250 hrs	3
		4a. Facility Name (24302 Half	if not institution	n, give s	street and n	umber)	- · ·	4	b. City, Tov Hollywo		ocation of	Death			County of			
Funeral		5. Social Security N		6. Sex	-	7. Age (In	n yrs. last bir	thday)	If Under		If Under	24Hrs.	8. Date of E				hplace (State	or
Director		212-68-7			1 2 F	go (57	Yrs.	Months	Days	Hours	Min.	05/0	,		Foreign	Washii ^{Intry)} DC	ngton
		Usual Residence o											<u> </u>					
v any		10a. State	10b. County			100	c. City, Town	or Location	on								10d. Inside Ci	
and show	5	MD	St. M	lary	s	i	Holly	wood									1 X Yes 2	2 No
MOTE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cond (Health and Mental Hygiene, not (Health and Mental Hygiene, not I filem 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu 24302 Ha		ne Po	nint F	Rd.			10f. Zip Ci	ode 0636				_	zen of Wha			
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5-0 ed wi fygier officer	ပ္ပ	17. Father's Name								18	.Mother's	Name (First, Middle	, Maiden	Surname)			
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Be	James A	rthur	Dav:	is Jr.	•							Hawk					ł
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", in jury or other traumatic event, the Medical Examiner:	ဥ	19a. Informant's Na Margaret				ner	19	b. Mailing 24302	Address Half	Street a	and Numb	er or Ru	ral Route Ni Rd • H	umber, C olly	ity or Town	State MD	Zip Code) 20636	
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Baltimore, permit. Pages I are Department of Hee Important: If iten njury or other tr		21. Signature of Fu	neral Service	License	e								eph Ga					016
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kaminer		Immediate Cause (or condition resulting			LCONO		Morp!	nine	Intox	1ca	tion					-		
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687 ertific ding p		23b. Was decedent past 12 months		ne					al death	3	Ectopic	pregnan	Су		Month	Da	ay Y	rear ear
Sox 687 death certific e attending for use as t	Physicia	1 Yes 2 N	10 9 🔲 Un	known	9 Unkn	nant at time	e or death	5 Oth	er (Specify									
O. B. I the de by the	Phy	Part II. Other signi	ficant condi	ions c			t not resultin	a in the ur	derlying ca	use aiv	en in Parl	t I.	23e. Did	tobacco	use contrib	ute to t	he cause of de	eath?
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Division of Vital Records, P.O. sopital or Attending Physician: The law requires that thours after death. Ineral Director: After this certificate has been signed by filled in by the fumeral director, page 2 should be detac	Certification	3 Suicide	6 🗷 Cou	d not be rmined	1		le Far		-	iice bui	iding, etc.		or Town,	State) 2	4302	Hal:	f Pone 1	Point
Hospi 24 hou Funct	ర్థ	4 Homicide 29a. Certifier (Check only)	Certifying P	hysician						ne, date	and plac		Road ue to the cai		ywood d manner a			
To the Hos within 24 h To the Fur	edical	(5115511 5111)	Medical Exa	miner: 0		of examina	_											
F 3 F 8	Me	29b. Signature and	title of certific		na manner s	naicu.		<u></u>	29c. L	cense i	number			29d.	Date signe	d (Mon	th, Day, Year)	
		Pre const	Asex	Koill	mx					C.M	.E.			Nov	ember 2	23, 20	12	
		30. Name/and add	ss f person	who cor	npleted cau	se of death	(Item 23a)			_								
		Pamela E. S		ID A	Assistant		Examine			nore	Street,	Baltim	ore, MD	21223				
St Regist	ate	31. Date filed (Mont	h, Day Year)	112	1/6	egistrar's S	ignature	racke			-							
Regist	10-14	05E R II V.		117	110 000	144	44. 10	4.6.4										

12-08455 Reginald Datcher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reginald Datcher	1- For State Registrar	tate of Marylan	d / Department o Certificate o		d Mental		eg. No. 20	2 38919				
Physician/	Decedent's Name (First, Middentification)					Date of Dea Month	Day Year	3. Time of Death 0245 hrs				
Medical Examine	Reginald D 4a. Facility Name (if not institution		ner)	4b. City, Town, or	Location of D	Novembe	r 8, 2012 4c. County of D					
`	3410 Summer Breeze			Nanjemoy			Charles					
Funeral Director	5. Social Security Number 577–42–3765	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Yea Months Day		4Hrs. 8. Date of Bir Min. 08/17/	l F	Birthplace (State or or oreign Country)				
	Usual Residence of Decedent		Tra or T					1404 1				
ow any	10a. State 10b. County MD Char		10c. City, Town or Local					10d. Inside City Limits 1 X Yes 2 No				
ryland a-f show it once.	10e. Street and Number		Hanj	10f. Zip Code		11	0g. Citizen of What					
the Maryland n nr 28a-f sh tified at one Director	3410 Summer Br	eeze Place		20662	2		United St	ates				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", nr items 23a nr 28a-f shour inther traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director				/as Decedent of His Yes, specify Cubar		(Specify Yes or No lerto Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.				
ral", n	3 VVidowed 4 U	vorced If Yes, Give YP95	3–1955	Yes 2 X No			Specify: B					
hours natur			during	ent's Usual Occupa most of working life			16b. Kind of Busin	ess/Industry				
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exa	9th	, conege (1-4	, , , , , , , , , , , , , , , , , , ,	osive Ope	erator		Federa1	Government				
5-00 led win other		, Last)	l		18.Mother's N	lame (First, Middle,						
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	Sydney Datche 19a. Informant's Name/Relation		10h Maili	ng Addross (Stro	-	Thomas Da	ntcher mber, City or Town, S	State Zin Code)				
MD 21 nd 2 should in a 27 is man an unatic ev	Isadore Datch						ijemoy, MD					
nore, MD 21215-0036 nt of State and 2 should be filed within 72 hours after nt of Health and Mental Hyggiene. It: If item 27 is marked other than "natural", nither traumatic event, the Medical Examiner To Be Completed by 1	20a. Method of Disposition 1 XBurial 2 Crematic	- 2 Demoved from	20b. Place of Dispo	osition (Name of ce		Date	20c. Location - Ci					
Pages Pages nent of hant: I	4 Donation 5 Other S		MD Veter		tery 1	1/15/2012	Che1ten1	nam, MD				
Baltimore, ME permit. Pages I and 2 s permit. Pages I and 2 s Department of Health at Impurtant: If iteu 27 injury or other traum	21-3 g ture of Funeral Service Lyuza C. Thornton	Johnson 110058	D 1343	Name and Addres ornton Fune 39 Livinest	on Road.	Indian Hea	d, Maryland	20640				
Physician	23a. Part I. Enter the disease, of failure. List only one cause	r complications that cau e on each line.	sed the death. Do not enter	the mode of dying	, such as card	iac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death				
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):											
	Sequentially list conditions,	b.	onsequence or).									
iner		Due to (or as a co	onsequence of):					28				
ted Insit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):									
tO, e be executed ysician and burial - transit	- LINDENDED	d				.						
50, te be execute ysician and burial - tran		AMENDED 330 If you gu	tcome of pregnancy				23d. Date of de	liven				
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live birt	h 2 _ F	etal death 3	Ectopic pr	egnancy	Month	Day Year				
OX (OX (eath ce atth ce for use	1 Yes 2 No 9 U	nknown 9 Unknow		Other (Specify)								
D. B. at the d ached			eath but not resulting in the	underlying cause	given in Part I	. 23e. Did t	obacco use contribu	te to the cause of death?				
ires that signed be detailed	Diabetes Mellitus					1 Ye	s 2 No 3	Probably 4 Vnknown				
Records, The law requires, freate has been sig						24a. Was	psy prio	re autopsy findings available or to completion of cause of				
Reco						1 Yes	ormed? dea 2 No 1 ▼	Yes 2 No				
ician: certifi rector,	examiner?	Hospital:	patient 2 ER/Outpatie		of Death (Ch	neck only one)	Residence 6	Other: Seene				
S Physics Fer this ceral direction of T.	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury 28b. Time o		ury at Work?		how injury occurred					
On Conting	1 Natural 5 Per	(Month, D	ay,Year)	1	Yes 2 No	o						
Division of Vital Records, P.O. Box 6876 spital ar Attending Physician: The law requires that the death certificate north Directur: After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be detached for use as the I Certification: To Be Completed by Physician/M	2 Accident Inv 3 Suicide 6 Co	uid not be	of Injury - At home, farm, str	eet, factory, office	building, etc.	28f. Location or Town,		or Rural Route Number, City				
	4 Homicide 29a. Certifier 1 Certifying (Check only one)	Physician: To the best of	of my knowledge, death occ									
Tn the Ho within 24 I To the Fu completely	2 Medical Ex	and manner sta			ise number			(Month, Day, Year)				
1 /.	111/		15		.M.E.		November 8,					
NO. W	80. Name and address of person	n who completed cause	of death (Item 23a)									
(XX)	Russell Alexander M			0 W. Baltimore	e Street, Ba	altimore, MD 21	1223					
Stat Registra	9311137	יום ויצווניני	strar's Signature	well			I/A-I/	9				
3		17										

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Fardelmann Donald C. 3:45 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 204 E. Church St. Hebron Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Director 146-18-0358 Usual Residence of Decede 1 🕅 M 2 □ F 88 05/10/1924 New Jersey and Martai Hygiane. Is merked other then "neture!", or items 23e or 28e-f show reumetic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryiand 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Hebron 10f. Zip Code 10q. Citizen of What Country? Funeral 21830 USA 204 E. Church St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Sales Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Louis H. Fardelmann Lillian V. Crissey it. Page 1 and 2 should by rtment of Health and Mar rtent; if item 27 is merkinjury or other trsumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet C. Richardson/Daughter 844 Capt. Moore Rd., Rome, PA 18837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Importent: if ite
sny injury or oti
once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 10/23/2012 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Furieral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause terval Between Immediate Cause (Final disease or condition Onset and Death Priysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the attending physician and the for use as the burial-transit or Attanding Physician: The law requires that the death certificate be axecuted Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death To the Hospital or Attanding Physician: The law requires that the dea within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the a completaly filled in by the funeral director, paga 2 should be detached it. 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes Completed 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed: 2 No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3
Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Zong Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print 60x1733 Salu6-31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012012 A Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne **Arundel** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 27 1 **Funeral** 9. Birthplace (State or Foreign Days Hours 579-38-4871 Country) Director 1 □ M 2🛣 F 85 Oct 1927 Virginia and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medicel Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Mary1and Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Lincoln Parkway 21401 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify 3X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) 6 yrs Board of Education Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Merritt Ethel Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Carlesa Finney-Thomas(Daughter) 7917 Glengary Ct. Glen Burnie, item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11-12-12 Baltimore, Md. 21. Signature of Funeral Service Licensee Winname Records of SaciliSons Mortuary, Larry 1922 Forest Dr. Annapolis, Md. 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been considered by the constitution of the consti To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2-No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2-1 No |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) ignature and title of certifier 29d. Date signed (Month, Day, Year) vente /220/2 445 Defense Highway eted cause of death (Item 23a) (Type, Print)

State Registrar

ame and address of person who car

31. Date filed (Month, Day, Year)

Annapolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. 14, DO 2012 Forsyth, Jr. Harold Frederick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Montana 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 8/14/1925 121-16-6237 Director 87 Usual Residence of Decedent 28a-f show 10a. State 10c, City, Town or Location notified at Director Garrett Oakland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21550 U.S.A. 103 Red Run Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed "natural" 3 Widowed 4 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Land Man Oil Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ပ္ Forsyth, Sr. Harold Frederick Vera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Edna M. Forsyth/ Wife 103 Red Run Rd., Oakland, MD 21550 20a, Method of Disposition 20b. Place of Disposition (Name of Counter yes in the or other place) 20c. Location - City or Town, State Date Page 1 Important: If it any injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 11/18/12 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Newman Funeral Homes, P.A. 203 S. Second St., Oakland, MD 21550 23a, Part 1. Enter the disease, or complications that false death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final diac Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?
1 Yes 2 No 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other မ 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a, Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

10d. Inside City Limits

Black

Interval Between

Onset and Death

2012

1 Tes 2 X No

4:15 AM

To the Hospital or Attending

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Robin Bissell

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

124 Miller St., Grantsville, MD 21536

1003423

nsure All Copies Are Legible. h and Mental Hygiene

12-08450	Please Type or Print in Black Indelible Ink. En
Michael Leonard Ford	State of Maryland / Department of Health

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ledical Exami	ner	MICHAEL LEONAR								Month Novembe				2035 hrs	
		4a. Facility Name (if not institution	_	mber)		4b. City, Tow	n, or Lo	cation of	Death			ounty of E)eath		
		Route 225 and Ripley				Ripley					Cha				
Funeral			6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	Year Days	If Under Hours	24Hrs. Min.		,	1 _F	oreign	lace (State o	
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ours.		15. Decedent's Education (Spec		de completed)	16a. Deceder	t's Usual Oc					16b. Kind	of Busin	ess/Ind	ustry	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		SHIRLEY A. MC C	CANTS/ MUJ											S 7875	.0
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m 2243	. 4	22. Name and Address of Facility THORNTON JOHNSON MOO583 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLA											YLAND	20640	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death.										Approximate Between On	Interval
Medical.		Immediate Cause (Final disease	a. Multiple Inj	uries									- 1	Death	
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F × S	Me	29b. Signature and title of certifie	and manner s	naleu.		29c. L	icense i	number			29d. Date	e signed	(Monti	, Day, Year)	
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8		30. Name and address of person	who completed cau	se of death (Item	23a)										
00-8		Melissa Brassell, MD	Assistant Me			/. Baltimo	re Str	eet, Ba	Itimore	, MD 212	23				
S	ate	31. Date filed (Month_Day, Year)_		agietrarie Signatu	Iro.										
Regist	rar	31. Date filed (Month, Day, Year) NOV 1 3	12012 /	we a	1. pa	Ken									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 659 M aves Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death HOSPITAL Ster Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 07/20/1910 212-74-3742 102 Hours Country) Director 1 🗆 M 2 📉 F MD show 10a, State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Funeral Director Rock Hall MD Kent 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21661 USA 21700 Lovers Lane items within 72 hours after death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ori Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify "natural", 3 Widowed 4X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Samuel Walter Florence Warren Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other **-21700 Lovers Lane Rock Hall, MD 21661 Maureen Hynson/Grand Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 ** Removal from State Crematory Direct 11/30/12 Dover, DE 4 Donation 5 Other (Specify) nature Funeral Service License 22. Name and Address of Facility Bennie Smith Funeral 855 High ST Chestertown, MD 21620 23a. Part 1. Apter the disease, or complications that caused the death. Do not enter the mode of ing, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one call Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as consequence of) Examiner day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that the death certificate be executed -tran that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Pregnant at time of death 2 No the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No nours after death.

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To the Funeral D Medical retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Norse Practitioner: To the best of my knowle 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year)

State Registrar BROWN

STREET

CHESTERTOWN

100

Name and address of person who completed cause of death (Item 23a) (Type, Print)

C

32. Registrar's Signature

CARDO

1. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dav Year Month Davi 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Memorial Garrett Count akland 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV 1 M 2 □ Months Days Hours Min 6/26/1950 62 Director 235-74-1160 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits OH Morgan McConnelsville 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n Funeral 8835 Noth State Rt 60 NW 43756 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 K Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 12 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) technichan Health x-ray Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important. If item 27 is marked of any injury or other traumatic eve ပ Paul Guthrie Goldie Morris Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goldie Guthrie/Mother 107 Freeland Ave., Terra Alta, WV 26764 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/26/2012 norgantown, WV . Signature of Funeral Service Licensee 22. Name and Address of Facility Terra Alta, WV 26764 A.H. Wright Funeral Home, 105 Highland Avenue 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only ne cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ (COVERNALY VALCU Commany averiosclovets disease or condition 10avs Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical as the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Black 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\text{Yes} \) 2 \(\text{No} \) injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be State

Oa 31. Date filed (Month, Day, Year, 32. Registrar's Signature

Registrar

(Check

30. Name and address of pe

and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hand

29d, Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

1559

9. Birthplace (State or Foreign

White

Approximate Interval Between Onset and Death

Day

living

Year

10d. Inside City Limits

1 Yes 2 No

29d. Date signed (Month, Day, Year) D55258 Nov.7,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4609 Sleaford Road Bethesda, Md 20814 Wilks M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 9 2012 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla	-	artment of I tificate of I		and Mental	⊣ygier _{Reg.}		012	389	127
Ph	ysicia	n/	1. Decedent's Name (First, Middle	Gilb	art				2. Date o	f Death	Dav	Year	3. Time of Dea	
***	Medic kamin	al	4a. Facility Name (if not institution				4b. City, Town, o	r Location	NOV of Death	•	1 1 2 4c. County	2012	9:25 A	
أكام			Genesis Of W				Waldo	rf		- 1	Char			
	neral ector		5. Social Security Number 172 22 7923	6. Sex 1 ☐ M 2 🕱 F		s. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under Hours		Birth Day, Year 191	í 7	9. Birthp Coun	olace (State or For	reign
pt %C	# E	'n	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation		1-1-2				0d. Inside City Lir	mite
Marylar 8a-fsl	tified	Director	VA Fairf	ax		lexand:						ľ	1 X Yes 2	
th the l	t pe no		10e. Street and Number 8199 Tiswell	Drive			10f. Zip Code			10g.		What Cour	itry?	
eath wir	ar musi	Funeral	11. Marital Status	12. Was Dec	cedent Ever in		22306 Vas Decedent of H	ispanic Ori	igin? (Specify Yes or	No-	USA 14. Bac	ce - Americ	an Indian.	
Z1Z13-UU30 within 72 hours after death with the Maryland gigne. er than "natural", or items 23a or 28a-f sho	xamine	by	1 ☐ Never Married 2 ☐ Mar 3 🔀 Widowed 4 ☐ Divorced	If Yes, G	2 X No ive		f Yes, specify Cuba ☐ Yes 2 🏞 No		n, Puerto Rican, etc.) :		Blac	ck, White, o	etc.	
Z13-UU30 in 72 hours after e.	lical E	Completed	15. Deceder	nt's Education		16a. Deced	lent's Usual Occup	ation		16b.		usiness Inc		
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filed wi	vent, t	Be	17. Father's Name (First, Middle, L	,		bear	macress	18. Moth	er's Name (First, Mid		Priva en Surnam	-		
VIALYIAND Should be filed and Mental Hy z is marked off	natic e	To	Abraham John						sie Aike	_			_	
Mal 12 shou alth and 27 is n	r traur	1	19a. Informant's Name/Relations Ronald Gilber						er or Rural Route Nul Fran Dr.					
Baltimore, Maryliand Z1Z13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Innordant if file 27 is marked other than "natural", or items 23a or 28a-f show	or othe		20a. Method of Disposition 1	3 ☐ Removal from	n State	o. Place of Dispos cemetery, crem	sition (Name of natory or other place	e)	Date			- City or To		
baltimo permit. Page Department o	injury e.		4 ☐ Donation 5 ☐ Other (S	pecify)	C		ake Cre		11/13/12 bBriscoe				e, MD	
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Exam	niner	<u>-</u>	Sequentially list conditions,				nenti	a				_		
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he deary the ar	iched fo	Physician/M	1 ☐ Yes 2 🔊 No 9 ☐ Unknown	4 ∐ Pre 9 ☐ Unk	gnant at time o	of death 5 ∟	Other (specify)			_	MIC	onth	Day Year	
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ttendin death. tor: Aff	the fur	Certificate	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation				Yes 2 🗆						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and	sted fills	Medical	(Check 2 Medical E	xaminer: On the ba	sis of examinat	tion and/or investi	gation, in my opinic	n, death oc	place, and due to the ccurred at the time, da	te and place	ce, and due	e to the cau	se(s) and manner s	stated.
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80	10		30. Name and address of person v Dy-J05jin Va	2hopp	se of death (It	em 23a) (Type, P)	Tiato	n B	lud, Gle	130	ומנטט	ie, M	0,210	61
Re	Stat gistra	e	29b. Signature and title of certifier 30. Name and address of person v Dr. Josian Va 31. Date filed (Manth, Pay Year)	3 2012	egistrar's Sigi	nature 6	ule				<u>-</u>			

				AMEND PI LINE A-B, St	e or Prin	nt in Bland	ack In	delible In 12 TRT rtment of	k. Ens Health a	ure A and M	II Copies	Are Leç	jible.	
				State Registrar				ificate of				Reg. No. 2	12	38928
		Physicia Media		Decedent's Name (First, Middle, Last) BELINDA GRACE GA	ALBREA	TH					2. Date of Dea Month Octobe		Year 2	3. Time of Death 12:57 PM
(ang.	Examir		4a. Facility Name (if not institution, give street Upper Chesapeake I		enter	c	4b. City, Town, 6			<u> </u>		of Death	
		Funeral Director		5. Social Security Number 220-62-3011 6. Sex		(In yrs. last i	<i>birthd</i> ay) Yrs.	If Under 1 Year Months Days			8. Date of Birth			lace (State or Foreign Yland
		nyland a-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harford		10c. City, To		ation eet					1	0d. Inside City Limits 1 ☐ Yes 2X☐ No
		ith the Ma 23a or 28s st be notii	Funeral Director	10e. Street and Number 4707 Rocks Road				10f. Zip Code	2115	54		10g. Citizen of	What Coun JSA	
_	980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1	/as Decedent Evrmed Forces? ☐ Yes 2 【★ Yes, Give ear or Dates.			as Decedent of I Yes, specify Cub			ify Yes or No- lican, etc.)	Bla	e - America ck, White, e	etc.
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71 /2		Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	ns that caused to se on each line.	the death. D	o not enter	the mode of dyi	ng, such as d	/	respiratory arre		носк	Approximate Interval Between Onset and Death
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7	talF	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?			·		lace of Deat	h (Check	•	2 2 No	1 ∐ Yes	Z 🗀 NO
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salbreath	Division	oital or urs afte ral Dire		4 Homicide determined	building, etc.	(Specify)		t, factory, office			8f. Location (St City or Towr	, State)		
sall		To the Hosp within 24 ho To the Fune completely f	Medical	29a. Certifier (Check 2 Medical Examiner: On only or) 3 Certifying Nurse Prac	the basis of exa	amination and	d/or investig	ation, in my opini	on, death oc	curred at t	he time, date an	d place, and du	e to the cau	se(s) and manner stated.
9		To the with To the Com		29b. Signature and title of certifier				29c. Licens	e number	21	4	9d. Date signer	(Month, D	ay, Year)
				30. Name and address of person who complet	ed cause of dea	ath (Item 23a	a) (Type, Pr	or Cho	sapeal	Ke I	Dive	Bel A	10	MN2-1014
		Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	B. A	house			1		1 1	1 1017

			For State	State of M		nd / Dep		nt of H	lealth a		-	giene	Legibi	e.	0020
	Physicia Medi		1. Decedent's Name (First, Middle, L David Lawrence			<u> </u>	illicat	.e or L	Jealii	1	2. Date of De	. Day	10 %		ime of Death
	Examir		4a. Facility Name (if not institution, gi Baltimore Washin	ive street and number) agton Medic	al Ce	enter			Location of Burni				County of Do	/	
	Funeral Director		5. Social Security Number 277–18–7737 Usual Residence of Decedent	Sex 7. A 1.8274M 2 □ F	ge (In yrs. 87	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4/22/	y, Year)	9. (Birthplace (S Country) Oh:	State or Foreign
1	er death with the Maryland or items 23a or 28a-f show niner must be notified at	rector	10a. State 10b. County Maryland Anne A	rundel	10c. Ci	ty, Town or Lo	ocation	Mil	llersv	rille					ide City Limits
\geq	with the s 23a or 3 ust be no	eral D	10e. Street and Number 108 Melchior Ro	ad			10f. Zi	p Code	21108	3			zen of What	Country?	
174 U	s aft	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3KX Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Kyes 2 L If Yes, Give Year or Dates.	,		If Yes, spe	cify Cuba	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		4. Race - Ar Black, Wl Specify:		an,
1215	permit, Page 1 and 2 should e filed within 72 hour Department of Health and Mental Hyglene. Department: If item 27 is man ed other than "natural injury or other traumatic event, the Medical ODGs.	Complet	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4 or 5+	5+)	life. D	kind of wo	erk done d e retired)	ation Juring most		7		orpor		aw
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D.A.	Page 1 ar nent of He ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Spe			Place of Dispo cemetery, cren 1timor	natory or c	other place	e) ory	Da	te 9/2012		ation - City		
Baltimo	permit, Departr Imports any Inje		21. Signature of Fuheral Service Lice	nsee Old	1	i 4	2. Name ar 7 Dul	nd Addres	s of Facility	Joh	n M. Ta	aylor	Fune	ral Ho	ome
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	Voit To 1		29b. Signature and title of certifier	M			•	License	number -39	17		29d. Date	signed (Mor	nth, Day, Yes	2012
0	41241	1	30. Name and address of person who	11. 301 H	15 Rid	2/ D	RIVE	1 5	en	Burr	ne.	Mo	. 2	106	ſ <u>.</u>
	Stat Registra	.~	31. Date filed (Month, Day, Year)	012 32. Bégistr	ar's Signa	d.	ale	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Month Day November 21, 2012 Medical Examiner 1930 hrs Sharon E. Holder 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4941 Idlewilde Road Shady Side Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Days oreign Director Months Hours 217-72-2217 52 1 M 2 X F Country) 1960 Nov. 4, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Yes 2 X No MD Anne Arundel Shady Side the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4941 Idlewilde Road 20764 U.S.A. 23a noti Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 W Married Yes Specify: White 2 No specify: 3 Widowed Divorced If Yes, Give Yea Yes 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) than MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene.
Important: If item 27 is marked other that injury or other traumatic event, the Medical 12 Adminstrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William C. Parker Mary Lucille Williams Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James L. Holder/Husband 4941 Idlewilde Road, Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-27-2012 Lakemont Mem. Grdns Davidsonville, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death aMixed drug Intoxication (Methadone, Tramadol and Diazepam) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to infriedlate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g934 12-6-12 sm attending physician or use as the burial -X UNPENDED The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of · has performed? death? certificate Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes ٩ 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu accidental overdose 1 Yes 2 X No death. fd 11-21-12 |fd19:20 pm 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4941 Idlewilde Rd. 3 Suicide Could not be (Specify) Single Family Home Shady Side, MD. determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 12

Registra DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Catherine Waunita Harvey 5:30 АМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Garrett 4702 Gorman Road Oakland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. (Month Day Year) Country Director 214-16-2306 1 M 2 X F Yrs Usual Residence of Deceden or than "neturel", or items 23e or 28e-f show 10b. County 10a. State 10c. City, Town or Location Pege 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health end Mentel Hygiene. ant: If item 27 is merked other than "neturel", or items 23e or 28e-f sho 10d. Inside City Limits Directo 1 🗌 Yes 2 🎜 No Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4702 Gorman Road 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3. Widowed 4 □ Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking Homemaker 12 Be other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary F. Rowan Harry J. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4685 Gorman Road, Oakland, MD 21550 Charlotte Mousch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State ò Important: It eny Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) White Church Cemetery 11/29/2012 Oakland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami After this certificate has been signed by the ettending physician end funeral director, page 2 should be detached for use as the buriel-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) မှ

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.

Funerel Director: After this certifics etely filled in by the funeral director,

Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 - Pending Natural injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Terrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one nd title of certifier 29d. Date signed (Month, Day, Year) 1)30035 11/26/2012

who completed cause of death (Item 23a) (Type, Print)

MEMORIAL DRIVE OPKLAND MD 21550 1027 lichtek M

State Registrar

Certificate:

Medical

31. Date filed (Month, Day, Year) NOV 27 2. Registrar's Signature

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hummel Henry 2:00 am Joshua 9019 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2463 Lower New Germany Rd. Frostburg Garrett Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Months Director 215-16-4394 1 X M 2 . F 93 Sept. 30, 1919 Maryland Usual Residence of Deced show ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 🗆 Yes 2 😿 No MD Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 2463 Lower New Germany Rd. USA items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other than "natural", or iter Black, White, etc ò 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Dates. W within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Completed WW2 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Auto Body Shop event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ပ Daniel Hummel Sarah Ellen Turner traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Loretta C. Hummel/Wife 2463 Lower New Germany Rd., Frostburg, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Grantsville Cemetery Nov. 27, 2012 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. altine P.O. Box 275, Grantsville, MD Part 1. Enter the disease, or complication shock, or heart failure. List only one caus that a led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ 1ac disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a conse del ce of) that initiated events and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performet Yes 2 death? certificate 2 🗌 No is after death.

ral Director: After this certificate

ral on by the funeral director, pr the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WOO 34 November 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 21536 31. Date filed (Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan	-			nd Me	ntal Hyg	giene			
			Registrar		Cer	tificate of	Death		R	Reg. No.	2011	38	933
	Physicia	n/	1. Decedent's Name (First, Middle, Last					2.	Date of Deat Month		Year	3. Time o	f Death
	Medic			Higgs, Sr.					vember	r 17	, 2012	8:45	P_M
	Examin	er	4a. Facility Name (if not institution, give s			4b. City, Town, o		Death			County of Dea		
امو		щ	Hospice House of S		st hirthday)	Callaw If Under 1 Year		d Hre I o	Data at Dist	_	t. Mary		
	Funeral Director		210 2/ 00/5	ØM2□F 75		Months Days		Min.	Date of Birth (Month, Day,			thplace (State ountry)	or Foreign
			Usual Residence of Decedent	J.W. 2 - 1 / J	Yrs.			Ma	ay 25,	193	7 Mary	yland	
	sho	ţō	10a. State 10b. County	10c. City	, Town or Loc	cation						10d. Inside C	ity Limits
	Mary 28a-f	Director	MD St. Mary	's Leon	nardtov	v n						1 🗌 Yes	s 2 ₺ No
	the or	٦	10e. Street and Number			10f. Zip Code				10g. Citi:	zen of What Co	ountry?	
	s 23	Funeral	21855 Newtowne Ne	eck Road		20650				Uni	ted Sta	ites	
	item			12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H Yes, specify Cub	fispanic Ongir an, Mexican, I	in? (Specify Puerto Rica	Yes or No-		14. Race - Ame		
ဗ္ဗ	after I', or	ğ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes 2 🖾 No			,		Black, Whit Specify: Wh:	-	
8	ours sture	Completed	3 Widowed 4 Divorced	Year or Dates.	10.0								
5	72 h	횬	(Specify only highest grad	de completed)	(Give k	ent's Usual Occu ind of work done O NOT use retired	during most of	of working		16b. Kir	nd of Business.	/Industry	
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D	led v	Be	17. Father's Name (First, Middle, Last)		·	-	18. Mother	's Name (Fi	rst, Middle, N	Maiden S	iurname)		
<u>_</u>	fenta fenta rked tic ev	₽	John Leon Higgs,	Sr.			Heler	n Vic	toria :	Pilk	erton		
ary	hould hould be me send hould		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street	and Number	or Rural Ro	oute Number,	City or	Town, State, Zi	p Code)	
Σ	d 2 a alth alth 27 i		Briana M. Higgs (D	aughter)	21777	Potomac	View 1	Dr.,	Leonar	dtov	vn, Md	20650	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 ahould be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. They detected: If the 27 is merked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	20b. P	lace of Dispos	sition (Name of	ice)	Date	,	20c. Lo	cation - City or	Town, State	
<u>Ĕ</u>	Page nent ent: I ury o		4 Donation 5 Other (Specify	Mat Fune	tingley	natory or other pla Gardiner e P.A. Cre	matory	11/19	/12	Leo	nardtow	n. MD	
<u>a</u>	spart spart nport ny inj	Ιİ	21. Signature of Funeral Service License		22	Name and Addre	ess of Facility	dinar	Funer				
ш_	205 20	Ш	Danielle	Nard		41590 Fe	nwick	St.,	Leonar	dto	vn, MD	20650	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	lications that caused the death e cause on each line.	n. Do not ente	r the mode of dyi	ng, such as ca	ardiac or re	spiratory arre	est,		Approxima Interval Bet	
	nysician/		Immediate Cause (Final disease or condition	CVA								Onset and	
بر	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):								-
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	sit o	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):								
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89	pentifi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar							3d. Date of de	liven	
ŏ	atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d		Ectopic pregnan Other (specify) _	cy				Month		Year
Records, P.O. Box 687	the d	hys	g 🗌 Unknown	9 Unknown									
<u>~</u>	is that the death certifica ignad by the attending pl be detached for use as t	by F	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying cause g	iven in Part I.		23e. Did tob	bacco us	e contribute to	the cause of c	leath?
ds,	requires been sig should t	pet						_	1 X Y	es 2 🏻	No 3□P	robably 4 🗆	Unknown
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ल	aicien: The law certificeta has l irector, page 2 s	Be (25. Was case referred to medical examiner?			26. P	lace of Death	(Check on			0		
5	hyak hls ce al dire	၉	1 Yes 2 No	lospital: 1 Inpatient 2		t 3 ☐ DOA Ott	ner: 4 🔲 Nurs	sing Home	5 🗌 Reside	ence 6	Other (Spec	ity 4050	olee
6	Ing P	ate	27. Manner of Death i Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur	k?		. Describe ho	w injury	occurred	Ho	use
Ö	tend death tor: A	iii	Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		-		Yes 2 N	No					
Division of Vital	or At after of Direct In by	Certificate:	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)		et, factory, office		28f.	Location (Str City or Town		Number or Ru	ral Route Numb	oer,
۵	Hoapital or Attending Physicien : The law requires that the death certificate be executed the fours after death. Euhours after death. Euhorata Intercor. After this certificata has been signad by the attending physicien and etely filled in by the funeral director, page 2 should be detached for use as the burlai-transity filled in by the funeral director.		29a. Certifier 1 Certifying Physi	cian: To the best of my knowle	odgo dogth o	sourced at the time	o data and a	1000 000		(-)	.	a de ad	
	P Hoa 24 h Fun etely	Medical	(Check 2 L Medical Examin	er: On the basis of examination	and/or investi	igation, in my opini	ion, death occi	urred at the	time, date and	d place,	and due to the	cause(s) and ma	nner stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral di	2	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of m	y Kriowieoge,	29c. Licens		anu piace,			s) and manner a signed (Mont)		
	7-0			2011		¥	MS	57	51			-2012	
			30. Name and address of person who co	empleted cause of death (Item	23a) (Type, P	rint)						010	
)			Jennifer Schwidt	40900 Merchan		,	rdtown,	, Md :	20650				
	Stat		31. Date filed (Month, Day, Year)	32. Régistrar's Signat	ure /	e. del							
	Registra	ar	NOV 2 0 2	012 Servera	p. 19								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	Otate of	Marylan				na ivi	Citairiy	giene	onlo	38934
			State Registrar			Cer	tificate of D	Death			Reg. N	2012	. 30334
П	Physicia	n/	Decedent's Name (First, Middle, Las	,						2. Date of De Month		ay Year	3. Time of Death
	Medic		Thelma Flor		Hunter					10	30	2012	10:30A M
	Examir	er	4a. Facility Name (if not institution, give		,		4b. City, Town, or				40	c. County of Dea	uth
-	,		Arcola Health an 5. Social Security Number 6. Se				Silver					Montgo	
	Funeral Director			M 2 XF /.	Age (In yrs. Ia		Months Days	Hours	Min.	8. Date of Bir (Month, Da	th y, Yea <i>r)</i>		rthplace (State or Foreign ountry)
Ŀ	-		Usual Residence of Decedent	LIN Z LAY	0)	Yrs.				11/05/	1922	2	DC
	and shov	ō	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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	the I		10e. Street and Number		•		10f. Zip Code				10g. C	itizen of What Co	ountry?
	s 23c	Funeral	901 Arcola Ave.				20902				USA	1	
	death item ner m		11. Marital Status	12. Was Decede Armed Force			Vas Decedent of His Yes, specify Cubar					14. Race - Ame	
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21215-0036	ours a	Completed	3 Widowed 4 Divorced	Year or Date:	s.								
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D	led w I Hyg othe		17. Father's Name (First, Middle, Last)			DOCE		18. Mother	's Name	(First, Middle,			
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ary	hould Named No ma		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street a	nd Number	or Rural	Route Numbe	r, City o	r Town, State, Zi	ip Code)
	id 2 sealth an 27 i		Novella E. Matthe	ws/Daugh	nter	1376	Underwoo	d St.	NW,	Washi	ngto	on, DC 2	0012
Ore	of He of He fiten		20a. Method of Disposition 1 X Burial 2 Cremation 3 C	D		ace of Dispo	sition (Name of natory or other place	e)	D	ate	20c. l	ocation - City or	r Town, State
<u>Ĕ</u>	Page ment ant: I		4 Donation 5 Other (Specification 5		aic		coln Ceme		11/0	7/2012	Bre	ntwood,	MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sig. a. re of Funeral Service Licens	ee		22	. Name and Address	s of Facility	Mar	shall-	Marc	h Funer	al Home
ш	<u>205 # 9</u>		fant I Indees	m MO	1057		4217 9th	St. 1	NW W	ashing	ton,	DC 200	11
			23a. Part 1. Enter the disease, or companion or hock, or heart failure. List only or	olications that cau ne cause on each	sed the death line.	. Do not ente	r the mode of dying	g, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between
	Pnysician/		Immediate Cause (Final disease or condition	Cerel	rovasc	ular I	Disease						Onset and Death years
	Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):	Vascular						
		P.	Sequentially list conditions,	-	years								
	D sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence or):							
	and	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):							
	cate be executed physician and s the burial transit	dical				,							
760	cate phys	w	_	d									
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		n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			1	100000				23d. Date of de	liverv
õ	eath certifica attending p	ician/M	23b. Was decedent pregnant in the past 12 months?	1 Live Bir 4 Pregnar	th 2 🗌 Fetal nt at time of de	death 3	Ectopic pregnancy	у				23d. Date of de Month	elivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Month** Month Caroline Janie 1550 M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA SALISBUM HICOMICO Center REGIONAL MEDICAL Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign) 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours Min. 213-22-5870 **Director** 86 1 □ M 2 🕦 F Oct. 6 Maryland Usual Residence of Decedent 10b. County or than "natural", or items 23a or 28e-f sho 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Princess 1 ¥ Yes 2 □ No Maryland Somerse 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2185 Division 3073 U.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Black Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Campbell Soup. Co. 10th grade Worker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Importent: If item 27 is marked othe eny Injury or other traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester Sr. Sallie Beauchamo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Hayward Faulk - daughter ct. Archimedes Pikesville, MD, 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Princess Anne MD Oaksville Com. Cemeters 11/17/12 22. Name and Address of acility Anthony E. Ward Jr. F. H. 21. Signature of Funeral Service Licensee Hampden Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cormany disease or condition min Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 🖾 No မ 1 Inpatient 2 KER/Outpatient 3 I DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending Work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who complet d cause of death (Item 23a) (Type, Print) Charles B. 31. Date filed (Month, Day, Year) State

Registrar

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:01AM Patricia Lynn Hardman 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbur (coasta) Dorgeoff at the WICOMICO Lake . Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 579-60-9524 **Director** 1 🗆 M 2 🕱 F 55 12/21/1956 Washington, DC 23a or 28a-f shov 10b. County 10c. City, Town or Location with the Maryland Director Maryland Worcester Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 21811 USA 205 Windjammer Road 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Worcester County Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant 12 Board of Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ William Augusta McClosky Florence Regina Poore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Sea Turtle Way, Newport News, VA 23601 Department of Health Important: If item 27 Callie B. Hardman/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/14/2012 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 24. ario 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Break Cancer Mess state Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Wunknown r this certificate has been signal director, page 2 should h Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Il Director: A Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat and title of dertifier 29c. License number 29d. Date signed (Month, Dav. Year) 063199 11112.

State Registrar 30. Name and

31. Date filed (Month, Day,

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SALISBURY HD. 21804

address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatu

AMEND #26, PER VERBAL 6933 11/30/12 TRT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Oct. **Physician** Kathleen Rose Hare 30, 11:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1001 Terrace Court Hampstead Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 21 € 170-24-1260 92 31, 1920 England Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "sector Experiment must be notified at 1 ☐ Yes 21 No Director MD Carroll Hampstead the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21074 1001 Terrace Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. <u>}</u> Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene.

7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Thompson ျ Charles A. Gout 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 14235 Rambo Rd. Felton, PA 17322 Arthur S. Hare, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 3 permit. Pages 1
Department of H
Important: If iter
any injury or ott remetery, crematory or Middletown 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 Freeland, MD 4 ☐ Donation 5 ☐ Other (Specify) emetery 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licensee 24 New Freedom, PA 17349 Second St. les Ν. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending physical for use as the t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Tilnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an The certificate 1 □Yes 2 ☑No Division of Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	ems ar mus	-une	1221 Bollinger R 11. Marital Status	. Was Decedent E	ever in U.S	. 13. V	Vas Dece	dent of Hisp	anic Origin? (Sp	ecify Yes or No		14. Race - Am	
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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee	5					of FacilPrit ton Rd.				Chapel, PA 21157
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Sugar C	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E124 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	I death 3	Ectopic Other (s _i	pregnancy pec <i>ify</i>)				23d. Date of c Month	lelivery Day Year
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	ne Hospit in 24 hour ne Funera pletely filk	Medica	29a. Certifier (Check only one) 3 Certifying Physici	: On the basis of e	xamination	and/or invest	tigation, in	my opinion,	death occurred a	at the time, date	and place,	and due to th	e cause(s) and manner stated
-	To the within To the complex c		29b. Signature and title of certifier	76 000				c. License n					nth, Day, Year)
						232/ /	2.1		1705				r 12.2012
			30. Name and address of person who com Hayan bha'i Pang	suri ya	MD	349	Ma	lcolm	Dr.	westr	nin	stev.1	4D 21157
	Sta Registr		31. Date fied (Month, Day, Year)	32. Registra	ar's Signat	ure							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-State Registra Amend #20B Per FH JM 11/967##198420f Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11/4/2012 6:24 PM George Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months 579-29-3176 Director 1 🏿 M 2 🗆 F 82 Yrs 9/27/1930 Guyana Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5746 Colorado Avenue NW 20011 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Private permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Josha Jackson Rose Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith E. Jackson/ Spouse 5746 Colorado Ave., NW, Washington DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Ft. Lincoln Cemetery 11/20/2012 1X Burial 2 Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road, Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Sepsis resulting in death) Medical Due to (or as a consequence of): **Examiner** Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings avallable prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this y filled in by the funeral di 28c. Injury at work?
1 Yes 2 No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending Investigation ☐ Accider☐ Suicide Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a the Funeral Dimpletely filled 🚣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one)

ZJM

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Da

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Tahmina K. Ahmed, 831 University Blvd., Silver Spring, MD 20903

egistrar's Signatu

29c. License numbe

D0060100

29d. Date signed (Month, Day, Year)

11/5/2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er	4a. Facility Name (if			ımber)			City, Town, or		f Death		4	c. County	of Death		
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Director		260-15-58		1 X M 2 □ F	5	2 yr	s. Mon	iths Days	Hours	Min.	(Month, D	,,		Cour	ntry)	
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Page nent o ant: If		1 🔀 Burial 2 🛭 4 🗀 Donation		3 Removal from Recify)		-		or other place		FPT	17. 201	12	CHELT'S	NHAM.	MARYLAND	
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		A Donation 5 Other (Specify) MARYLAND VETERAN CEMETERY: SEPT. 17, 2012 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licensee LYDIA C. THORNTON, PER DVR AND VETERAN CEMETERY: SEPT. 17, 2012 CHELTENHAM, MARYLAND 22. Name and Address of Facility THORNTON, FUNERAL HOME, P.A. 3439 LIVINGSTON RD INDIAN HEAD, MD 20640														
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Noveleien (23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition MYOCARDIAL INFARCTION														
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fing P h. After tl funera	ate:	27. Manner of Death 1 □XNatural	5 Pending	(Mo	e of injury nth, Day, Year)	28b. Tim inju	iry	28c. Injury work?			28d. Describe	how inju	iry occurr	ed		
Attender of the death of the py the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Plac	e of Injury - At I		, street, fa		res Z 🗆 r	-	28f. Location ((Street a	nd Numbe	er or Rura	l Route Number,	_
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of the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical Ex	Physician: To the aminer: On the ba Nurse Practitions	asis of examinati	on and/or ir	rvestigation	n, in my opinior	n, death occ	curred at	the time, date	and plac	e, and due	e to the ca	ause(s) and manner stat	ed.
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Stat	e .	DANIEL BC 31. Date filed (Month			GREENE Registrar's Sign				PID e	<u> </u>	Λ1					
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Teresa Lynn King 2012 7:30 Medical <u>October</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 100 Overlook Dr. Apt. Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Director 216-90-7659 Usual Residence of Decede 45 09/28/1967 Delaware 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
Item 27 is merked other then "netural", or iteme 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Overlook Dr., Apt. C 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 9 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry st grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Security Security Guard 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Garland Fitzgerald Jeanette Ellen Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33122 Longridge Rd., Parsonsburg, MD 21849 Philip M. King/Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If its eny injury or ot 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 10/24/2012 Salisbury, 21. Signature of Funeral Se ²² Name and Address of Facility at Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Romason 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YOUAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CORDNAR YRS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and deed betached for use as the burlai-transit To the Hospital or Attending Physician: The law requirss that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attsnding physician and that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1-Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 TNo Yes 2 WN 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

24

Division of Vital

Baltimore, Maryland 21215-0036

1346 5.

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 8 Sterling S. Keyes 20°11′2 11:04A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 136-26-5424 1**X** M 2 □ F 22 1934 78 Apr New Jersey Usual Residence of Decedent 28a-f shov 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Odenton 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or itema 23a 1005 Samantha Lane Apt 403 21113 USA permit. Paga 1 and 2 should be filed within 72 hours aftar daath v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema any injury or other traumatic event, the Madical Exeminer mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Union Free Elementary/Secondary (0-12) 12th College (1-4 or 5+) 8yrs Educator School District Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Willaim S. Keyes Mildred Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances R. Keyes(Wife) 1005 Samantha Lane Apt 403 Odenton, Md.21113 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 11-12-12 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Manusme Brenders of Sacilisons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospitai or Attending Physician: Tha lew requires thet the daath cartificete ba executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettanding physician e for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown After this certificete has baen si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, only one) 29b. Signature a 29c. License number 851F00C

Registrar
DHMH 17 Rev 06-2011

State

+.*4105, Balthwore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1 3 2012

6701 N. Chales

Pegistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 15 2012 Paula Marie Kisko 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Garrett Memorial Hospital Garrett Oakland 9. Birthplace (State or Foreign Country)
PA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) 07/28/1929 Davs Min Director 181-24-9403 1 □ M 2 🕱 F 83 Yrs Usual Residence of Deceden show or 28a-f shov notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD McHenry Garrett 10e. Street and Number 10f. Zip Code rms 23a or r must be r ö 10g. Citizen of What Country? Funeral 238 Wagner Road 21541 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Milchak John Skubak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marianne K. Vaughn / Daughter P.O. Box 331, McHenry, MD 21541 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2012 Cumberland, MD Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or At ending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' within 24 hours after eath

To the Funeral Director: After this certificate 2 🗆 No 2 🖃 N 1 Yes Yes the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2- No ည 1 Inpatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natura! 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 15/1 1550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson 311 North Fourth St Suite II Oakland, MD 21550 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:40 AM KRIEWALD 2012 CLARA ALVERTA NOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Alice Byrd Tawes Nursing Home Crisfield Somerset . Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** Days (Month, Day, Year 1 🗆 M 2 💢 F Months Hours Min Director 214-12-3965 93 1919 Maryland Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits aţ 10c. City. Town or Location illed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 X No Marion Station Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 5790 Charles Cannon Road 21838 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. , or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file rtment of Health and Mental | rtant. If item 27 is marked on njury or other traumatic eve Ernest Barrett Mattie A. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Thomas (Daughter) P.O. Box 195 - Marion Station, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 XBurial 2 Cremation 3 Removal from State St. Paul's Cemetery 11/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Marion Station, MD 21. Signature of Funery Perior Lonse

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DEMINITIA ALZHEIMERS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Pregnant at time of death Day 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCVD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes ၉ ER/Outpatient 3 DQA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 24 hours after death. Funeral Director: A Accident Suicide Investigation
6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year)

Vijay Karumbunathan, M.D. - 201 Hall Highway, Crisfield, MD 21817 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 23 2012 7:20 A M Les Callette Corinne S. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 🗆 M 2 🍱 F Months Days Hours Min. 1272071930 Mar∀land 81 Director 212-34-0009 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Salisbury Wicomico Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 907 Spring Ave. ural", or item I Examiner n 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: other than "natural", Completed 3 K Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Domestic Be Page 1 and 2 should be filed of ment of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Corinne Troy Samuel Biggs Schofield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Spring Ave., Salisbury, MD 21804 Kevin Les Callette/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/27/2012 Salisbury, MD Cemetery Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and as the burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ **To the Funeral Director**: After this certificate has been signs completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to prical Be 26. Place of Death eck only one examiner? Hospital: Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature a

Sta

30. Name and address of person wh

Registrar

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November MERLE LEWIS Μ. 2012 6:30A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hillhaven Assisted Lvg. Nursing & Rehab Center Adelphi 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days May 12, 1918 226-14-2217 Covington, Virginia 94 Director 1 □ M 2 🕅 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Adelphi Maryland Prince George's 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States Funeral 20783 9720 Riggs Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married څ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) own home Housewife Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Laura Robinson မှ Lonnie Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9720 Riggs Road Adelphi, Maryland 20783 Joanna Haley -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place)
Maryland National Mam. Park 11/14/2012 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami nding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Hospital or Attending Physicien: The law requires that the death to 24 hours after death.

Funeral Director: After this certificate has been signed by the other in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease; Hypertension; Hyperlipidemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \ No 1 ☐ Yes 2Ã No To the Hospital or Attending Physicien: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🖔 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🙆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) November 7, 2012 CIM D055559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #312 Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) State NOV 09 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Alice A. Lusk Nov. 80 2012 13:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner McCready Memorial Hospital Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1 □ M 2 1 214-42-9741 Director 68 31, Aug. 1944 MD. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 No Director MD. Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 26926 Fairmount, Road 21871 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 <u>ک</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Co0wner Seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Allen Franklin Horner Frances Minnie White Horner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Lusk Husband 26926 Fairmount RD., Westover, MD. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery 11/13/2012 Princess Anne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, MD. 21853 Her the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EFEBRO **Physician** /Medical Due to (or as a consequence of) Examiner TEPIOSCLETO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner by the attending physician and stached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 2 2 ER/Outpatient To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-12-2012

State Registrar

JG Samiano MO 31. Date filed (Month, Day, Year) NOV 1 3 2012

30. Name and address of person who comp

eted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elma Loretta Layton 540 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TENINSULA HICOMICO If Under 1 Year If Under 24 K **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 213-22-7103 Hours (Month, Day, Year) Director 1 M 2 K F 85 Usual Residence of Decede 06/12/1927 Maryland 28a-f show filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or Items 23a or 28a-f sho other treumatic event, the Mo Scal Examiner must be nutified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Wicomico Maryland Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1937 Pineway 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 1 Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha College (1-4 or 5+) Seamstress Clothing Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Herman Elliott Mary Agnes Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Layton Sr/Son E. Elizabeth St., Delmar, MD 21875 408 1 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 11/15/2012 Salisbury, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Holloway Funeral Home professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Injury that initiated events Examiner Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral D

completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

gistrar's Signatu

CATION

SHICKOS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year SSENGAL Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HESTER RIVER HOSPITAL TOWN **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Days Hours Min. Country) **Director** 252-14-2125 1 M 2 X 95 **GEORGIA** 12/23/1916 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD QUEEN ANNE'S CENTREVILLE 10e, Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 400 BLACK DUCK DRIVE <u> 21617</u> UNITED STATES Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 XWidowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. ANTIQUE DEALER ANTIQUE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ HENRY BRODNAX JESSIE DEARING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra SUE HANSEN / DAUGHTER 400 BLACK DUCK DRIVE CENTREVILLE, MARYLAND 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 11/10/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Kick S 23a. Part 1. Enter the lisease, ir condishock, or heart failure. List only o ations that caused the death. Do not enter the mode of dying, such ne cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a nsequence of **Examiner** epris dus Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Due to (or de a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the attend 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes Yes 2 the funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at work? of or Attending F after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending thin 24 hours after death. 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D71027 MD RD D71027 and address of person who completed cause of death (Item 23a) (Type, Print) CHESTERTOWN MD 21620 UGUSTO S. CONTI 100 BROWN STREET State Registrar

DHMH 17 Rev 06-2011

12-07949

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Kevin Munch 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** CHRISTOPHE 0551 hrs October 20, 2012 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Hours Min. Months Director 214 96 5121 1 X M 2 F 32 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show ACCOMACK **ESILITMORE, MD 21215-0036**permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked others in the marked others. iten 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, <u>the Medical Examiner must be notified at once.</u> VIRGINIA HORN TOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23395 USX TRAILS END 5/04 SAIL FIN DRIVE Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: WKITE ğ 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NONE GRADE DISABIL GED Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ DELORES MUNCH MICHAEL STANSBERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES MUNCH SHORT SIO4 SAIL FIN DRIVE POBOX 182 HORNTOWN UP 23395 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State CHINCOTENGUE VIRGINIA ISLAND CREMATORIUM OCT 23 2012 4 Donation 5 Other Specify: 22. Name and Address of Facility Fox & HOLSTON FUNCABL TOME 5649 CHICKEN CITY ROAD CHINCETERCUE 2332 21. Signature of Funeral Service Licensee Del Fre - VIRGINIA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Pneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and the detached for use as the burial - transi Physician/Medical AMENDED 23a, 27, per me, g934 12-6-12 smX UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? director, page ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 Inpatient 2 V ER/Outpatient 3 DOA ဥ 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 21, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 32. Registrar's Signature arke Registra

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Division of Vital Records, P.O. Box 68760, na or Attending Physician: The law requires that the death certificate be as after death. 1 Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	Physician/Medic	1 Yes 2 N		10 011	known	but not ros	culting in the	undorlying	001100 0	ivon in Pa	et 1	230 Did	tobacco	usa contribu	ito to th	ne cause of death?
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		Theodore M					kaminer		Baltim	ore Str	eet, Balt	imore, M	D 212	23		
Sta	te	31. Date filed (Monti	h, Day,Year)	2010 32	Registrar's	Signature	e Spari	Kad								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Joseph Mastripolito 2012 November 1624 P ^M Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 703-07-4089 Director 1 X M 2 D F 90 July 21, 1922 Pennsylvania ст в merked other then "netural", or itsms 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10b. County within 72 hours efter deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1)(X) Yes 2 - No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 U. S. A. 4104 Yardley Court 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces δ Black, White, etc. 1 Never Married 2 M Married 1 X Yes 2 No White 1 ☐ Yes 2 🕅 No Specify: 3 Divorced Specify: Completed Year or Dates. 1940-86 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Bureau of Engraving (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bookbinder and Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Mastripolito Clara Masciantonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If Item 27 eny Injury or other tronce. Joan Marie Mastripolito/Wife 4104 Yardley Court, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Latholic 11/12/2012
Church Lemetery 20a. Method of Disposition 20c. Location - City or Town, State Pege 1 Depertment of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bowie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HYPERKALEMIA disease or condition resulting in death) Medical Examiner RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury signed by the ettending physicien end d be deteched for use es the burial-trensit ARTERY DISENSE, The law requires that the death cartificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ this certificete hes been signe ret director, pege 2 should be o Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a Was an death? 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: Within 24 hours effer death. To the Funerel Director: After this certifice erel Director: After this certific filled in by the funerel director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **□** Natural 5 Pending injury Investigation 1 Yes 2 No 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated NOV. 08, 2012 HOSPITALIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILLANUEVA -Parkwa MARIA Medical 2001 31. Date filed (Month, Day, Year) Registrar

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Wilma Helen Mark 12:15 P M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2710 Summerview Way #104 Annapolis Anne Arundel 8. Date of Birth
(Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign 362-20-2647 Hours Michigan Director 1 🗆 M 2 🗶 F 88 1924 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Director be notified MD Anne Arundel Annapolis 1X Yes 2 □ No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ms 23a must be Funeral 2710 Summerview Way #104 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black White etc Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Yeoman Health and Ment tem 27 is marked ther traumatic e Unknown Trollop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8338 Washoe Pine Lane Charlotte, NC 28215 Andrew Mark/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ortment of hortant: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** 11/8/2012 Waldorf, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Approximate Immediate Cause (Final Onset and Death Physician/ Shortness of Breath disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Chronic Obstruction Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Chronic systolic & diastolic Heart failure hysician and the burial-trans Due to (or as a consequence of) attending of for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy 5 Other (specify) ____ signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 performed? Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 X Natural 5 Pending work? Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 68760

Registrar DHMH 17 Rev 06-2011 Suela Kaba, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

129 Lubrano Drive Suite 100 Annapolis, mD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maria Michelon Morgan November 2012 12:00 p.Mm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 130-62-2321 1 M 2 XF 47 05/02/1965 Usual Residence of Deceden New York th and Mental Hyglene. 27 is marked other then "natural", or items 23e or 28a-f shov traumatic event, the Mostical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u>Maryland</u> St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 20653 46536 Millstone Landing Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien 7 is marked other ti Systems Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawrence Michelon Jesse Modetti 1 and 2 should by Health and Meith and Meith and Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Morgan/Husband 46536 Millstone Landing Road, Lexington Park, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Importent: If ite eny Injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre Charlotte Hall, MD 11/16/2012 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signa Edward N. Brinsfield, M00052 Jr. Hollywood Road, Leonardtown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospitel or Attending Physician: The lew requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

%chmidt

30. Name and address of

Jennifer 31. Date filed (Month, Day, Year) 40900 Merchants Lane, Suite 205, Leonardtown,

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

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mar Antonio V	alle	-Majano 1- For State	Sta	te of Maryland		tment o <i>ificate o</i>		and Me	ental Hy	_		201	2 3895
Physici	an/	Registrar 1. Decedent's Name	e (First, Middle	Last)	- 00717	neate o	Deam			2. Date of De	Reg. No. eath		3. Time of Death
ledical Exami		Omar	Anton	io Valle	Mai	ano				Month Novemb	Day er 4, 20	Year 012	1843 hrs
		4a. Facility Name (it	f not institution	, give street and number)		• •	vn, or Locatio	on of Death		40	. County of Dea	
		12815 Holdr	idge Road				Silver S					Montgomery	
Funeral		5. Social Security N	umber 6	5. Sex 7. Aç	ge (In yrs. las	t birthday)	If Under Months	1 Year If Ur Days Hou	nder 24Hrs. urs Min.	7		Fore	Birthplace (State or eign
Director		none		1XM 2 F	26	Yr				6/25	5/19	86 E1	Soursalvador
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City. T	own or Loca	tion						10d. Inside City Limits
*		MD	Mont	gomery			Sprin	na					1 Yes 2 No
Aaryland 28a-f show	cţo	10e. Street and Nur		<u> </u>			10f. Zip C		_		10g. Citi	zen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once.	Director	3408 Ra	ndolp:	h Road			20	902			El	Salvad	lor
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death or iter	Funeral	1 X Never Marrie		1 Yes 2	No X				Salva	adora	n	White, etc. Wh	ite
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2 hour "natu	ted	Elementary/Seco		fy only highest grade cor College (1-4 or				cupation (Giving life, DO NO			100. 1	Kirid or busines	s/iridusii y
5-0036 Hed within 72 l Hygiene. d other than ",	Completed	8	, (5)	J = 1000	,		Labo	orer			Т	rash/F	Rubbage Co
5-00 ed wil tygier other	ပ်	17. Father's Name (First, Middle, L	ast)				18.Moth	ner's Name	(First, Middle	, Maiden	Surname)	···
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be			alle Herna						lajano			
O & B . 3. 1	2			p(Type, Print)fat]								ity or Town, Sta	
e, MD 2 1 and 2 shou Health and In item 27 is n		F'redi Om 20a. Method of Disp		lle Herna				of cemetery,		Date		SPLII Location - City	ng, Md20902 or Town, State
ore local port of H				3 Removal from St		ematory or of	ther place) Cemet	erv	11/1	15/20	1 2 Są	n Rafa	el Obraju-
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.		4 Donation 5 21. Signature of Fur	Other Sp	offy:	den	22-1	Name and A	Idress of Faci	ility. – – –		ler	o, San	Salvador,
Ba Depa Imp		Mile	Olh	Sh		92	4116	olumb:	NALDI ia BI	vd.S	ilve	r SERVI	ng,Md20910
Physician		23a. Part I. Enter the failure. List onl		omplications that caused	the death. D	o not enter	the mode of	dying, such as	s cardiac or	respiratory a	rrest, sho	ock, or heart	Approximate Interval 8etween Onset and
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		or condition resulting	ig in death)	Due to (or as a cons	equence of):								
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that the d		Part II. Other signif	icant condition	ns contributing to deat	h but not resi	ulting in the	underlying ca	ause given in	Part I.				o the cause of death?
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Reco The law icate has	J W										formed? 2 ✔ N	o death?	Yes 2 No
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SiOr Atteoc r death ector: by the	cati	2 Accident		gation Nov 4, 2012 28e. Place of Ir		1847 hrs	et factory o			28f Location	(Street a	ind Number or F	Rural Route Number, City
Division pital or Atteodin ours after death. eral Director: Afilled in by the fu	Certification:	3 ✓ Suicide 4 Homicide	6 Could determ	not be			ot, idolory, o	moo banang,		or Town,	State)	, Silver Spring	2210
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To the How within 24 h	Medical		Medical Exam	Iner: On the basis of exa and manner stated.	mination and	l/or investiga	ition, in my o	oinion, death	occurred at	the time, dat	te and pla	ace, and due to	the cause(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 2012^{ea} Richard C. Mortimer 4:55 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death First in Quality Care Waldorf Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year))ct. 14, 1939 **Funeral** 9. Birthplace (State or Foreign Hours 217-36-8690 73 **Director** 1**X**□ M 2 □ F Yrs Washington, D.C ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director X Yes 2 □ No <u>aPlata</u> <u>Maryland</u> Charles 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6705 Horseshoe Drive 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 27 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify "natural", 3 X Widowed 4 □ Divorced Specify Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Band Director Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Earl Mortimer Mary Baker permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic eonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candice Taylor/ Daughter 6705 Horseshoe Dr., LaPlata, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens !Nov. 8 , 2012 Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of **Examiner** Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has perform within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 2 🗎 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea h 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

DO.

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Linda Marie Maddox-Allen Medical Nov 6 12:30 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Temple Hills 4505 Cedell Place Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 25, 1957 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Maryland Director 217 68 8380 1 □ M 2**)(**)(F 54 or 28a-f shov Page 1 and 2 should te filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marilled other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 4 1 Prince George's Temple Hills 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4505 Cedell Place United States 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Legal traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o 2 Harold Joseph Maddox Mary Eleanor Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 Cedell Place, Temple Hills, MD 20745 Joyce Maddox (Sister) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 4 Donation 5 ☐ Other (Specify) Clinton, MD Resurrection Cemetery November 13 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Lit 100257 Ferry Road. <u>Clinton MD 20735</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Amyotrophic Lateral Sclerosis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): physician and s the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of preg*n*ancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be director, page 2 s autopsy performed Yes 2 X director, 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $\stackrel{\star}{K}$ Residence 6 \square Other (Specify) 1 ☐ Yes 2 TXNo After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. within 24 hours after death

To the Funeral Director: A

completely filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Jocelyne D637 W8 DQ-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 4041 Powder Mill Road, Calverton, MD 20705 31. Date filed (Month, Day, Year) Registrar's Signature 32 State NOV 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Theresa S. Mancuso 2012 10:40 AM November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico 304 E. Walnut Street Delmar If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 103-30-1574 1 M 2 X F 73 Aug. 20, 1939 New York item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9714 Loblolly Avenue 19956 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🖾 No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) be filed within College (1-4 or 5+) home homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ည Margaret Miles Henry Goth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. (Daughter) Annie Dethloff 304 E. Walnut Street Delmar, MD 21875 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-16-2012 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Lady of Lourdes Cem Blades, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 E. Grove St. Delmar, 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfo 1 Tes 1 🗌 Yes 25. Was case referred to medical Ba 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my colo 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salish Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State	of Maryla		artment of l tificate of	Health and I Death		2.0	112	38959	
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	Reg. No		3. Time of Death	
	Physicia Medic		Alice Moore						Month	may 11	Year 2 3/7	10:38 M	
	Examin		4a. Facility Name (if not institution	, give street and nu	mber)	_	4b. City, Town, o	r Location of Death		4c. County			
تعمر			2814 Iverson St				Temp1e			Prin	ce Ge	orge's	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. 71	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 6/24/1			ace (State or Foreign K Carolina	
-	Director		238-64-8667 Usual Residence of Decedent		/ -	115.			6/24/1	941	Nort	n Carolina	
7	and show	٥	10a. State 10b. County		10c. C	City, Town or Loc	ation	-			10	Od. Inside City Limits	
Mony	waryi 28a-f otifie	lec	MD Prince	George's	s Te	mple Hi	.11s					1X Yes 2 □ No	
4	a or i		10e. Street and Number		·		10f. Zip Code			10g. Citizen of	What Count	ry?	
7	ns 23 must	Funeral Director	2814 Iverson St				20748			USA			
0	riter iner	F.	11. Marital Status	Armed Fo			Vas Decedent of F Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, et		
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Z 1	ygien her th	Be C	12th			Factor	y Worker			rriva	LE		
and File	e med ed ot even	To B	17. Father's Name (First, Middle, L	1				18. Mother's Nam	ne (First, Middle, i		e)		
Maryland	d Mer mark matic		Joseph Outerbri 19a. Informant's Name/Relationsl										
Na Na Na Na Na Na Na Na Na Na Na Na Na N	ger land a should be lined within 7z inous affect death with the waryland style fleath and Mental Highene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Ernestine Tille		r			and Number or Rur $\mathrm{Blvd.}\mathrm{Ft}$					
Je,	of He fiter rothe		20a. Method of Disposition 1 Burial 2 □ Cremation	0 □ D16	20b.	Place of Dispos	sition (Name of eatory or other place	20)	Date	20c. Location	- City or Tov	vn, State	
	ment tant: l		4 Donation 5 Other (S		Wo	odlawn	Cemetery	11/16		William:			
baitimore,	Department of Important: If ite any injury or ot once.		21. Signature of Funeral Service L	icensee				ss of FacilityMars				Home	
			23a. Part 1. Enter the disease, or	complications that	caused the dea							Approximate	
- Pt	www.	0.8	shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on ea	con line.	Pasti	40	-tz.	- H	Tat	200	Interval Between Onset and Death	
	Medical		mmediate Cause (Final disease or condition resulting in death) a. Arterios Lead Tr. Aprendiate Action Conset and Death Due to (or as a consequence of):										
	xaminer	ř	Sequentially list conditions, b.										
D	sit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	or as a consec	que les ofj.							
xecut	ohysician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):							
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o / o ficate	g ph) as the		IE EENAN E	1						1			
x 00 /	attending ph d for use as th	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	nancy tal death 3	Ectopic pregnance	ev.		23d. Da	te of deliver	y	
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alorA	ours after death. eral Director: After this certificate he filled in by the funeral director, page		4 ☐ Homicide determi		ng, etc. (Specif		et, factory, office	ļ	28f. Location (St City or Town		er or Hurai H	oute Number,	
lospita	t hour unera	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the b	est of my knov	vledge, death or	ocured at the time	, date and place, ar	nd due to the cau	se(s) and manne	er as stated.	e(s) and manner stated.	
to the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours a To the Funeral C completed filled	— r	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of n	ny knowledge, de	eath occurred at the	e time, date and plac	e, and due to the	cause(s) and ma	anner as state	ed.	
ř	≥ 7 8		2 Sp. dignature and title of certifier	V BL	25/10	20				9d. Date signed			
	2 5M	ł	30. Name and address of person v	vho completed caus	e of death (Iter	m 23a) (Type, Pr	int)	/	- /	1		apland	
			SMUAdor Su	lues Te	300	1 1/04	rital.	Drive,	Chan	rele	141	Inplomed	
	State	-	31. Date filed (Month, Dev. Yely)	2012 32/2	egistrar's Signa	atur.	getical			11		,	
	Registra				•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 3:00 FM 2012 Medical 4a. Facility Name (if not institution, give street and numb 4c. County of Death Washington 4b. City, Town, or Location of Death Hagers town **Examiner** Golden Retreat Assisted Living 5. Social Security Number 220 – 50 – 3581 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 60 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthpic OH 1 🗆 M 2 🗗 F (Month, Day, Year) 1952 Director Ma'y item 27 is marked other then "neturei", or items 23e or 28a-f shove other traumatic event, the Medical Examinar must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Washington Hagerstown 1X☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 21740 673 Highland Way 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married, 2 Married Maryland 21215-0036 1 ☐ Yes 2 Å No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John H. Scheufel Cutis Atkins 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) Joni Scheufel 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 4 Adams Court, Gettysburg, PA 17325 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ፟ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of importent: if it eny injury or o once. 4 ☐ Donation 5 ☐ Other (Specify) Dugan Crematory 21, '12 Nov. Shippensburg, PA Juneral Service 21. Signature of 22. Name and Address of Facility Dugan Funeral Home & Crematory 23a. First 1. diet. The disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if he disease or conditions.

Immediate Cause (Final disease or conditions) 51 Asper Drive, Shippensburg, PA 17257 Approximate Interval Between Onset and Death Physician/ ALLEROTIE COMPINION ASCULAR ISENSE disease or condition resulting in death) VEHS. Medical Due to (or as a consequence of): Examiner DEPENDENT DIABLETTS MERCIUS NSVUN TUMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transi Cause (Disease or injury CORONARY VASTULAR that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the at Id be detached for 9 Unknown 9 Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pagn 1 ☐ Yes 2 🗗 No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 1 🔀 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier m/) Nov. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IN-CHICKMIDWN QMoin 190 GHALL (COM) AUMB

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

32.

istrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Prin			nsure All Copies h and Mental Hyd	•				
		For State Of Ivid		tificate of Deati	h	Reg. No.2012	38961			
Physicia Medic		1. Decedent's Name (First, Middle, Last) Winifrede W. Peters			2. Date of Dea Month Novembe	ath Dav Year	3. Time of Death 3:50 P M			
Examin		4a. Facility Name (if not institution, give street and number) 416 Duvall Lane		4b. City, Town, or Location	on of Death apolis	4c. County of Dea	Arundel			
Funeral Director		182-12-1042 1□M2⊠F	(In yrs. last birthday) 88 Yrs.		der 24 Hrs. 8. Date of Birt rs Min. (Month, Day	h 9. Bir , Year) Co	thplace (State or Foreign ountry) ennsylvania			
and show at	or		10c. City, Town or Lo				10d. Inside City Limits			
Maryla 28a-f s otified	Director	Maryland Anne Arundel		Annapoli	.s		1 ☐ Yes 2xxxNo			
with the 23a or	Funeral D	10e. Street and Number 416 Duvall Lane		10f. Zip Code 2140)3	10g. Citizen of What Co				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	10	Vas Decedent of Hispanic f Yes, specify Cuban, Mexi		14. Race - Ame Black, Whit	e, etc.			
2 hours "nature	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during n	nost of working	16b. Kind of Business	/Industry			
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d 2 should alth and h		19a. Informant's Name/Relationship (Type, Print) David V. Peters/son			mber or Rural Route Number Annapolis, M		o Code) 1403			
ige 1 and nt of He tr. If item?		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State		natory or other place)	Date	20c. Location - City or				
permit. Pa Departme Importan any injun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Baltimore	Crematory Name and Address of Fa	11/13/2012 Cility John M. Tay	<u>Baltimore,</u> ylor Funera	<u>Maryland</u> 1 Home			
o ar E De		23a. Part 1. Enter the disease, or complications that caused to			oucester St.					
Pnysician/ Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and the condition and the condition are condition and the condition an	CIESTIVE consequence of):	= 8	FAILURE	_	Approximate Interval Between Onset and Death			
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pital or ours afte		building, etc.	(Specify)		City or Town	n, State)				
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of machine in the basis of examiner. On the basis of examiner in the basis of examiner. To the basis of examiner in the basis of examiner. To the basis of examiner in the basis of examiner.	mination and/or invest	igation, in my opinion, death	n occurred at the time, date ar	nd place, and due to the	cause(s) and manner stated			
To t With COT		29b. Signature and title of certifier Red But Clum 80n r	10	b 50 C	/	29d. Date signed (Month				
45		30. Name and address of person who completed cause of dea		, 000 20	stgate Road lis, Maryland					
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar 32. No. 1 3 2012	S Signature	all	- Jack					
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DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene? | | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 10. 2012 10:20P M Nathan James Patton, Jr. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 105 East Second Ave. Mtn. Lake Park Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 217-14-4820 1 🔀 M 2 🗆 F 88 Yrs. 7/25/1924 West Virginia Usual Residence of Deceden 27 is marked other then "natural", or items 23a or 28a-f shov treumetic event, the Medical Examinar must be notified at. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD Garrett Mtn. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 U.S.A. 105 East Second Ave. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Town of Loch Lynn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I ည Naomi Davis Nathan James Patton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 105 E Second Ave., Mtn. Lake Park, MD 21550 Beverly Patton/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Deer Park Cemetery 11/13/12 Deer Park, Maryland 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License Second St., Oakland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tine. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physiciani Ta Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Duri to for as a consequence of ate has been signed by the attending physiclan and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the business. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💆 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Octifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D23979 11,13012 of person who completed cause of death (Item 23a) (Type, Print) 30. Na MD 21550 Goralski Mp N Fourth St., Oakland, 311 31. Date filed (Month, Day, Year) NOV 1 6 2012 32. Registrar's Sign State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 896 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 52 AM ARIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern linton 4124 ANO 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 579 Director 28 052 1 □ M 2 🕅 F 20-1920 MARYLAND should be filed within 72 hours and mental Hygiene.
I and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show arke event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8400 2074 454 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 A No Specify. If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Black ear or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) George Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DAMES John permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8400 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location Date 1 Surial 2 Cremation 3 Removal from State 5-12 4 Donation 5 Other (Specify) YON 21. Six ature of Phieral Vervice License Name and Address of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Exami attending physiclan and I for use as the burial-transit Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day ate has been signed by the a page 2 should be detached it 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after deam.

To the Funeral Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yeş 2 1 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **Natural** 5 Pending work? 1 Yes 2 No 2 Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d, Date signed (Month, Day, Year) BO-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOA. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **PACULBA** 2012 MARY ELIZABETH Nov 7:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3614 Silver Spring Edelmar Terrace Montgomery Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 233-52-9967 1 □ M 2 🔀 F Yrs Oct. 29, 1934 78 West Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10 10g. Citizen of What Country? be Funeral 3614 Edelmar Terrace 20906 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🗓 No by Black, White, etc. 1 Never Married 2 Married ō 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Director Private other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ William Andrew Ellison Nellie McClure and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18202 Littlebrooke Dr., Tammy L. Rhoades (Niece) Olney, MD Department of Health Important: If item 2: any injury or other t other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Riverda Tematory Park Place)
Crematory 1 Burial 2 X Cremation 3 Removal from State 11/16/2012 Riverdal, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee CC0341 22. Name and Address of Facility Jordan Funeral Service. 4001 Benning Rd., N.E., Washington, DC 20019 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one de Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC disease or condition BREAST CANCER Years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🎛 No Month Day 1 ☐ Yes 2 ☑ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 2 X No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗓 No Other: 2 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

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Olney.

30. Name and address of person process of completed cause of death (Item 23a) (Type, Print) Dr. Chitra Rajagopal #327

2. Registrar's Sign

29c. License number

D 42452

MD 20832

29d. Date signed (Month, Day, Year)

November 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State o	of Maryla		artment of I		and Mental Hy	2	0112	38	965
		Registrar 1. Decedent's Name	e (First, Middl	e, Last)		007	incate of t	Jean	2. Date of De	Reg. No.(_ ath	016	3. Time o	
Physicia Medic		JOHN RICI	HARD Q	JINN, SR.					Month NOVEME	ER 8.	2012		3 A M
Examin	er			, give street and nun			4b. City, Town, o	r Location of	Death	4c. Ce	ounty of Death		
Funeral	0	CHESTER J 5. Social Security No		HOSPITAL C	ZENTER 7. Age (In yrs.	last hirthday)	CHESTER If Under 1 Year		4 Hrs. 8. Date of Bir	KEN		-l (Ot-1-	
Director		218-20-3 Usual Residence of	118	1 X M 2 □ F	- Age (III yrs.	86 Yrs.	Months Days	Hours	Min. (Month, Da	y, Year) . 926		place (State of ntry) YLAND	or Foreign
and show	ō	10a. State	10b. County		10c. C	ity, Town or Lo	cation					10d. Inside Ci	ity Limits
Maryli 28a-f	Director	MD	KENT		MAS	SEY						1 🗆 Yes	2 X No
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or ite	by Fi	11. Marital Status1 ☐ Never Marri	ed 2 XMar	Armed Fo	dent Ever in Urces?				in? (Specify Yes or No- Puerto Rican, etc.)	14	. Race - Ameri Black, White,		
OO3 ural", I Exa	led	3 Widowed	4 Divorced	If Von Civ	e	1	Yes 2 XNo	Specify:		Sp	ecify: WHI.	ГE	
1d 21215-0036 filed within 72 hours after death with the Maryland air lygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Completed	(Spe	15. Decede cify only highe	nt's Education est grade completed)		(Give F	ent's Usual Occup	during most c	of working	16b. Kind	of Business Ir	ndustry	
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illed w illed w orthe	Be	17. Father's Name (F	irst, Middle, I	_ast)		PARME	K	18. Mother	's Name (First, Middle,			<u> </u>	
Vlar d be t Menta arked	욘	THOMAS J.	QUINN	Ī				NELLI	E MOFFETT		•		
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page.		19a. Informant's Na	me/Relations	hip (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route Numbe	r, City or To	wn, State, Zip	Code)	0
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IMOR Page 1 ant: If it ury or of		1 🗆 Burial 2	X Cremation	3 Removal from	State	-	atory or other plac	· .	Date		tion - City or T		
Baltimor permit. Page 1 Department of Important: If is any injury or c		4 Donation 21. Signature	5 U Other (S	cense	CH				1/12/2012				
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a security and the second		shock, or hear	t failure. List d	complications that conly one cause on ea	aused the dea ch line.	ath. Do not ente	r the mode of dyin	g, such as ca	ardiac or respiratory arr	est,		Approximat Interval Bet	ween
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Geath of death of the atter	sicia	in the past 12 m 1 Yes 2			nant at time of		Ectopic pregnand Other (specify)				Month	,	ear :
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ing Pr ing Pr Viter th uneral		27. Manner of Death 1 Natural	5 Pendin	28a. Date of (Montal	of injury h, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe he	ow injury oc	ccurred		
SIOF ttend death death stor: A / the f	Certificate:	2 Accident 3 Suicide	Investig	gation	af Initiate At In			Yes 2 N					
LIVISION tal or Attendii rs after death. al Director: Af		4 Homicide	determ	ined 20e. Flace buildin	ig, etc. (Specif	y)	et, factory, office		28f. Location (S. City or Town		umber or Rura	Route Numb	er,
DIVISION OT VITAI RECORDS, P.O. BOX 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical E	xaminer: On the basi	s of examinatic	on and/or investi	gation, in my opinio	n, death occu	ace, and due to the cau	nd place, and	d due to the ca	use(s) and mar	nner stated.
To the vithin comp		29b. Signature and ti		12 0	O the best of fi	iy kriowiedge, de	29c. License		nd place, and due to the		igned (Month,		
6		1	Jun 1	Kylos,	m.D.		Da	17036	,	lil	19/15	~	
	[30. Name and addres	ss of person v	vho completed cause				0.4		_			
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		For State Registrar	State of Ma		artment of Health and N <i>rtificate of Death</i>	, 0	ene 3. No. 2 A 2	38966
		1. Decedent's Name (First, Middl	e, Last)			2. Date of Death	Day Yoar	3. Time of Death
Physicia /Medic		MARION YOST	RAY			NOVEMBER	10 2012	5:50 p ^M
Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	1
		Talbot Wing -			Chestertown If Under 1 Year If Under 24 Hrs.	To be desired	Kent	1 (0)
Funeral		5. Social Security Number 192–22–3711	6. Sex 7. Ag	ge (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 30 1	year) 9. Birti Cot 927 Penn	pplace (State or Foreign Intry) Sylvania
Director		Usual Residence of Decedent		00		racy 50 T	727 I Call	Syrvania
yland now		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
a-fsl	ctor	MD Kent		Chestert	own			1 X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code	109	g. Citizen of What Cou	intry?
after death with the Maryland or items 23a or 28a-f show mainer must be rectified at	ra	501 E. Campus	Ave. RM 201		21620		U.S.A.	
tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
, or i	by F	1 ☐ Never Married 2 【※Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 【XNo Specify:		Specify: W	hite
thou			nt's Education	16a. Dece	dent's Usual Occupation	16	6b. Kind of Business/I	ndustry
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e file al Hy l othe vent,	Be	17. Father's Name (First, Middle,	Last)			e (First, Middle, Ma	aiden Surname)	
Ment Ment arked	ျှ	Clarence Yost			Anna La	aPatina		
2 sho and Is ma		19a. Informant's Name/Relations			ng Address (Street and Number or Ru			
and lealth m 27 her to		Ronald L. Ray	(husband	-			, MD. 2190	
ges 1 If ite or ot		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State		matory or other place)		oc. Location - City or 1	
t. Pa rtmer rtant:		4 □ Donation 5 □ Other (5			mation Services 17		Smyrna, DE	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examitm I must be Indiffical at once.		21. Signature of Funeral Service		Ğ	2. Name and Address of Facility alena Funeral Home	e of Stepl	hen L. Sch	aech
	-	23a, Part Enter the disease, or			18 West Cross St. ter the mode of dying, such as cardiac			Approximate
		shock, or heart failure. List	only one cause on each li	ne.			,,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	а.	HEIMER	-S, END STA	10E		23 years
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ite be iysicia ne bu	ical		d					
ng ph as th	Physician/Medical	IF FEMALE:						
ath ce ttend or use	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnancy		23d. Date of deli Month	very Day Year
the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a	at time of death 5 [Other (specify)			Day 10a.
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requ been shouf	etec					240 W/00 00	24h Word av	toney findings available
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n: Th ficate n, pag		OF Management to madica			00.01	1 ☐ Yes 2	No 1 ☐ Yes	2 No
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Phy er this eral d	2:1	27. Manger of Death	28a. Date of Inju	ent 2 ER/Outpatie ury 28b. Time o		28d. Describe how	nce 6 Other (Spec	ory)
nding tth. :: Afte	ation	1 Natural 5 Pendir 2 Accident investi		ay, Year) Injury	Work? M 1 □Yes 2 □No			
Atter rr dea ector by the	iţics	3 ☐ Suicide 6 ☐ Could	nined 28e. Place of In	jury - At home, farm, sti	reet, factory, office		eet and Number or Ru	ral Route Number,
tal or s afte al Dir	Certification:	4 ☐ Homicide determ	bullaring, et	tc."(Specify)		City or Town,	orare)	
ospit hour uners		29a. Certifier Certifyi	ng Physician: To the best	of my knowledge, deal	th occurred at the time, date and place	, and due to the ca	use(s) and manner as	stated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner st					
To To Con	2	29b. Signature and title of certifie	A A MM	I am	29c. License number	587 29	d. Date signed (Monti	n, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELD A. NOBE MD 122 SEER

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department / Department /		∕lental Hygien	ne	
			Registrar Ce/	tificate of Death	Reg. I	No. 2 1 1 2	22967
Ï	Physicia Medic		1. Decedent's Name (First, Middle, Last) Louise Rostick		2. Date of Death 11/8/20	Pay Year	3. Time of Death 12:43 and m
	Examin		4a. Facility Name (if not institution, give street and number) 7715 Westover Lane	4b. City, Town, or Location of Death Clinton		4c. County of Death	orge's
	Funeral	e i	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g. Birthpl	ace (State or Foreign
	Director		386 34 6750 1 □ M 2★ F 81 Yrs.	Months Days Hours Min.	(Month, Day, Year 07/01/19		NC
	and show	řo	10a. State 10b. County 10c. City, Town or Lo			10	d. Inside City Limits
	Mary 28a-f otifie	Director	MD Prince George's Clinto	on			1 X Yes 2 ☐ No
	vith the 23a or st be n		10e. Street and Number 7715 Westover Lane	10f. Zip Code 20735		Citizen of What Count	ry?
	leath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by I	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🚰 No	f Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Spec <i>ify:</i>	Rican, etc.)	Black, White, et Specify:Black	
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Maryland 21215-0036	vithin 7; giene. er than the Me			O NOT use retired)	‴ Wa	shington Center	Hospital
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ryla	uld be d Men narke natic	1	Liston Smith		Cousar		
, Ma	d 2 sho salth and n 27 is i			ng Address (Street and Number or Rura Westover Lane			
Baltimore,	age 1 an int of He t: If iten / or oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition cemetery, crem	natory or other place)		Location - City or Tov	
altin	permit. Page 1 a Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other (Specify) Resurred 21. Signanupé of Funeral Service Lippensee 22	ction Cem. 11/1 Name and Address of Facility Bri	scoe-Ton		
ä	permi Depar Impon any ir		Mully Chroson 22	294 Old Washing	ton Rd.W		
	Anna de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della c		23a Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
ر الادر كار	Medical	M Y	disease or condition resulting in death) a. Due to (or as a consequence of):				Onoce and Boats
	Examiner	<u>_</u>	Sequentially list conditions, b.				
	ed nsit	mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Uisease or injury				
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09	ate be executed ohysician and the burial-transit	dica	d				
687	certifica nding p use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	
Вох	is that the death certific. gned by the attending is be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🔀 No 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)			y Day Year
P.O.	at the od by the detach	, Phy	g Unknown Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ds, F	requires the been signer should be a	ed by				2 ⊠ No 3 □ Proba	
Records,	law rec has bee ge 2 shc	Completed			24a. Was an autopsy performed?	prior to com	sy findings available pletion of cause of
Z Z	sician: The la certificate ha rector, page	OO e	25. Was case referred to medical	26 Blace of Death (Charle	1 Yes 2		2 □ No
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Division of Vital	ling Phys n. After this (funeral dii		27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how inju		
isioi	Hospital or Attending I 24 hours after death. Funeral Director: After stely filled in by the funer	Certificate:	2	M 1 ☐ Yes 2 ☐ No leet, factory, office	28f. Location (Street a		Route Number,
<u>≤</u> .	ital or urs afte ral Dir	al Ce	building, etc. (Specify)		City or Town, Star	te)	,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invest of the basis of examination and/or invest only one) 3 Certifying Nurse Practitioner: To the best of my knowledge,	igation, in my opinion, death occurred at	the time, date and place	ce, and due to the caus	e(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number		ate signed (Month, Da	
	205		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)	111	18/12	
	pu		Maren Mayhew 1801 McCormick	Dr Largo MD	20774		
	Stat Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 1 3 2012	relati			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 21 PER FH State of Maryland / Bepartment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEONARD T. RUSSO 4:45 P 2012 9 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHARLES CHARLOTTE HALL CHARLOTTE HALL CBOC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min **Director** 176-22-9460 1 🕅 M 2 🗆 F 81 19, 1931 NEW JERSEY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No WALDORF MD CHARLES 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20601 UNITED STATES 3605 MOSES WAY APT 315 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ▼ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced 1951 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION CONTRACTOR SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH RUSSO ROSE LORENZO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930 CARDAN DR, KNOXVILLE, TN 37909 LEONARD RUSSO, JR./ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, METRO CREMATORY 9/14/2012 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICES, P.A.
5635 WASHINGTON AVE, LA PLATA, DIANE WILKERSON PER DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 10 YEARS Physician ISCHEMIC HEART DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 10 YEARS DIABETES Sequentially list conditions Examiner if any leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events 10 YEARS DYSLIPIDEMIA the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes XXX No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) RESIDENT LIVING Hospital Other: 1 XXYes 2 No 4 Nursing Home 5 Residence 6X မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours 29a. Certifier 1 🔼 Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner (Check action and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated gest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tit of c 29c. License number 29d. Date signed (Month, Day, Year) 9/13/2012 D0055724 eath (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 06-2011

State Registrar JEAN-MARC ESTIME

MD

29431 CHARLOTTE HALL ROAD, CHARLOTTE HALL, MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fred Erwin Smith, Jr. Vovenber 19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 203-24-0840 1 X M 2 □ F **Director** 79 Jan. 11,1933 Pennsylvania 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21740 10g. Citizen of What Country? Funeral 502-C Lynnehaven Dr. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Erwin Smith, Sr. Mary Alice Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1086 Sunset Dr. Clarion, PA 16214 Alice M. Spindler-sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oti 20c. Location - City or Town, State 1 🗆 Burial 2 🖔 Cremation 3 🗆 Removal from State Smithsburg Crematory 11-23-2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dni Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 BNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Dialactes mellitus 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Xeertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 742 JW 10 ahmood. 5 MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Nathaniel N. Shorter Medical Novembe 9 2012 11:30 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11701 Croft Social Security Number Court Rowie If Under 1 Year | If Under 24 Hrs. Arunde 1 9. Birthplace (State 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** (State or Foreign Days Hours Min. 212-58-8052 Country) **Director** 1 M 2 D F 61 Yrs. Usual Residence of Decedent 1951 D.C. irel", or items 23e or 28e-f shov Examiner must be notified at 10a. State filed within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 8222 Clearwater Ct. 21144 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whife, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ó 11th Laborer Self Employed it. Pege 1 end 2 shouid be filed with ritment of Heeith end Mental Hygien ritent: If Item 27 is merked other I njury or other treumetic event, th æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nathan Shorter Helen Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20720 Croft Ct. Bowie, Md. Carolyn Henry (Niece)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Depertment of H Importent: If its eny injury or ott once. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11-12-12 Metro Crematory Baltimore, Md. 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Windame Receive of Socilisions Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) CARCINOM Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam use es the buriei-transit To the Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use es the buriel-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the ettending physicien funerei director, pege 2 should be detached for use es the burie Physician/Medical Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Residence Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Work:
1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Poornima Sharma MD 203 Hospital Dr Glen Burnie, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

determined

Medical

29a. Certifier

(Check only one) 29b. Signature and title

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date sig

12

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Rosati Suit Physician/ Month 11:32 PM Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-14-4838 90 **Director** 1 🗆 M 2 🔀 F 1/11/1922 Maryland Usual Residence of Decedent show 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel notified Annapolis 28a-f 1 X Yes 2 No ō 10e Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 1319 Homewood Lane 21401 U.S.A. "natural", or iten ledical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2**XX**No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Receptionist Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Rosati Elizabeth Barry I and 2 should If Health and Iv Item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Suit, II/son 24 Carvel Drive Annapolis, Maryland item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place)

Mary's Cemetery Burial 2 Cremation 3 Removal from State St. 11/10/2012 4 Donation 5 Other (Specify) Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home eral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia week Medical resulting in death) Due to (or as a consequence of) Examiner Dementia 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be the attending plant if for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2XXNo Month Pregnant at time of death Day Year the : 1 ☐ Yes 2X 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by urinary tract infections, renal failure Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed Yes 2 X No 2 \square No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2**X**No 1 Yes မ o the Hospital or Attending Physical 124 hours after death.

o the Funeral Director: After this ompletely filled in by the funeral directions. 1 XXnpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred XX Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 120 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 152756 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapelin Detense

State Registrar

Box 68760

P.O.

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			ntal Hyg	iene	38972		
				rtificate of Deati	h	R	eg. No. 4 1 2	1. No. 2012 30312		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)			Date of Deatl Month	Dav Year	3. Time of Death		
	Medic		Frances Elizabeth Smith 4a. Facility Name (if not institution, give street and number)	45 City Town and a still	in (Burth	10 3	30 2012	12:27P ^M		
	Examir	er		4b. City, Town, or Location	ion of Death		4c. County of Dea			
- P	Funeral		Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Date of Birth		thplace (State or Foreign		
	Director		577-52-2665 1 □ M 2 🕮 84 Yrs.	Months Days Hour		(Month, Day, 06/10/	Year) Co	nuntry) NC		
ī	d d	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			36/10/	1920			
	arylan a-f sh fied a	cto	MD Prince George's Colmar M					10d. Inside City Limits 1 Yes 2 No		
	ne Ma or 28	Dire	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Co			
	with t	eral	3403 40th Ave.	20722			USA	Sund y ?		
	tems er mu	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic	Origin? (Specify	Yes or No-	14. Race - Ame			
36	ifter of ", or amin	by	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexi 1 ☐ Yes 2 🕱 No Spec		ın, etc.)		k, White, etc. Black		
Ö	ours a	Completed by	Year or Dates.		ony.					
5	72 h	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during rr OO NOT use retired)	most of working	16b. Kind of Business,	of Business/Industry			
212	within giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+) Labor	,			Federal Go	Government		
ם	filed all Hyg	Be	17. Father's Name (First, Middle, Last)		lother's Name (Fir	rst, Middle, M	aiden Surname)			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	Fred Howard, Sr.	Lu	igenia	St	urdivant			
Jar	shou and is m raum					Route Number, City or Town, State, Zip Code)				
	and 2 Health em 2 ther t			Armhurst Rd	T					
200			1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre-	matory or other place)	Date	- 1	20c. Location - City or			
Baltimore,	permit. Page Department of Important: If any injury or once.			coln Cemetery 2. Name and Address of Fac						
ñ	permit. Departr Imports any inju		att Chare many	4217 9th St.						
		et,	Approximate							
Ц	Physician/		Mock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acute Hemorrhagia	a Ctralia				Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death) a. Acute Hemorrha_i Due to (or as a consequence of):	C SLIOKE						
	Examine	<u>-</u>	Sequentially list conditions, b. Uncontrolled Hyp	ertension				Chronic		
	A sit	mine	if any, leading to himme lists cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury							
	and al-lar	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
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3/60	ficate by g bhysias the	(i)	- 0.							
X 08/	endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy			23d. Date of de	livery		
POX	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/M		Other (specify)			Month	Day Year		
л. Э.	at the d by t detach	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pa	art I.	23e Did tob	acco use contribute to	the cause of death?		
ι, Τ	signe d be o	d by	Hypertension	, , , ,				robably 4 Unknown		
ğ	been	lete	Breast Cancer			24a. Was an	24b Were au	topsy findings available		
VITAI Records,	ne law e has age 2	Completed	breast Cancer			autopsy perform	prior to death?	completion of cause of		
r	an: Th tificat tor, pa	o o	25. Was case referred to medical	26. Place of D	Death (Check only	1 Yes 2	IX No 1 ☐ Yes	s 2 X No		
N I	ysicia is cer direc	To B	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatien	- Other:			nce 6 🗆 Other (Spec	ifv)		
Ö	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury				v injury occurred	,		
0	tendin leath. cor: At the fu	ertificate:	2 Accident Investigation	M 1 ☐ Yes 2	? □ No					
DIVISION OF	or At after of Direct in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
ב	spital	_	29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death	occurred at the time, date a	and place, and du	ue to the caus	se(s) and manner as st	ated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and recompletely filled in by the funeral director, page 2 should be detached for use as the burial-Hansi or the funeral director.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death	h occurred at the t	time, date and	place, and due to the	cause(s) and manner stated.		
	Talk to		29h Signature and title of certifier	20c Licence numbe	25	1 00	d Data signed (Manth	Day Vear		
			Viang Ning, attending phy	escan Doc	0/2673	>	10/30/	1(2.		
_			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	^ ~ ~	D 2.10	che no	2078C.		
	Stat		31. Date filled (Month, Day, Year)	pital Di	116/	ACV C) / P(P.	20 /03 .		
	Registra	-	30. Name and address of person who completed cause of death (Item 23a) (Type, F 3. Date filed (Month, Day, Year) 32. Registrar's Signature 100 0 9 2012							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lillian R. Silverman November 7, 2012 11:05 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 217-26-5633 Director 1 M 2 X F 93 Baltimore, MD April 15,1919 filed within 72 nous and tall Hygiene.

et other than "natural", or items 23a or 28a-f show and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 U.S.A. 1121 University Blvd. West, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Black, White, etc. β Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ပ Israel Roseman Freda Edelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1301 Heather Crest Terrace, Silver Spring, MD 20902 1 and 2 s of Health a item 27 i Morris Edeson, son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of 1 Durial 2 Cremation 3 Removal from State Lebanon Cem. 4 Donation 5 Other (Specify) Mt. November 8,2012 Adelphi, MD 21. Signature of Funeral Scales Licens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., N.W., Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Pneumonia resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin g physician and as the burial-transit Tricuspid Regurgitation Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day ed by the ar 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been sig completely filled in by the funeral director, page 2 should the state of the completely filled in t 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🖸 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 X No 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D D0067279 Nov. 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910 <u>Alaqarsamy Veerappan,</u> MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 09 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 M Gustave Saridakis November 6:35 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 15334 Manor Village Lane Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ☒ M 2 ☐ F Months Hours Min. July 6, Country) Director 94 Yrs 93-01-5748 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c City Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 TNo Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15334 Manor Village Lane 20853 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 Yes 2 No Specify. Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other 1 Inspector US State Dept Be 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be file
Department of Health and Mental h
Important: If item 27 is marked ot
any injury or other trainment 18. Mother's Name (First, Middle, Maiden Surname) ပ Komianos Saridakis Anastasia Zarpas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Alex Saridakis/Wife 15334 Manor Village Lane, Rockville MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Nov. 1 2012 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12. 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Rockville, MD Signatur of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Keharel I Jutes 500 University Blvd. W., Silver. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition a Cardiomy opathy Medical resulting in death) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ed for use as the burial transform To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 XN 25. Was case referred to medica æ 26. Place of Death (Check only one) 2XXNo 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5X Residence 6 Other (Specify, eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completed fi 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MUM D39793 November 8, 2012 Name and address of person who completed cause Christopher J. Mays, MD bmpleted cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, #207, Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 09 acke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Franklin Delno Slade 2012 Nov. 11:31 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours NC 05/19/1945 238-70-3303 **Director** 1 X M 2 □ F 67 28a-f show "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hertford Woodland NC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1731 NC Highway 561 West 27897 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates : If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. To is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Store Owner/Operator <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Washington Slade Irma Lassiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Gladys Douglas / Sister 1725 NC Highway 561West Woodland, NC 27897 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/17/12 Woodland, NC Slade Family Cem. 21. Signature of Funeral Se 22. Name and Address of Facility Reynolds Funeral Home Inc. 321 North Maple St. Ahoskie, NC. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death CARDIAC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner GASTRO INTESTINAL Esque dally list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and-tran Due to (or as a consequence of): physician are the burial-1 Physician/Medical Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2X ER/Outpatient 3 IDOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D61555 se of death (Item 23a) (Type, Print) Name and address of person who completed ca MAYO HOSPITAL DOUGLAS

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month B Sjolander Margaret Stewart 3:10 2012 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1117 Riverside Drive Salisbury Wicomico Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Min. **Director** 216-09-0504 1 🗆 M 2 🕱 F 97 09/26/1915 New Jersey or 28a-f show notified at be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No Maryland Wicomico Salisbury 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1117 Riverside Drive 21801 USA ıral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ragnar Sjolander Ida Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne S. Underwood/Daughter 1117 Riverside Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Wicamico Memorial Park 11/17/2012 Salisbury, MD ☐ Donation 5 ☐ Other (Specify) Signatur Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (Dompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ arteriosclerata vant diseas Mean Medical resulting in death) Due to or as a consequence of) Examiner nerunsion Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an Were autopsy findings available prior to completion of cause of death? has autopsy perform After this certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) enrich me 2012 (I.U) odney 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

ALISBURY

Registrar's Signat

DIVISION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ores ovembre 6:20 AM Medical 7017 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-24-9333 **Director** 1 □ M 2 🕮 F 91 Yrs June 14, 1921 Washington, DC show 10a. State 10b. County notified at 10c, City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Montgomery <u>Burtonsville</u> 10e. Street and Number Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r 10f, Zip Code 10g. Citizen of What Country? Funeral 3415 Greencastle Road 20866 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates Specify:White 1 Yes 2 No Specify Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygier
Important: If item 27 is marked other t any injury or other traumatic event, th Engraver Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hugh Harstin Mabel Louise Hamann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Marie Mata/Daughter 15512 Clayburn Drive, Laurel, MD 20707 Baltimore, Date 8 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 0, 2012 1 🗆 Burial 2 🗵 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Letter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician provascula 1seus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last nding physician ause as the burial Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Unknown g Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 Yes 2 No Yes 2 WN 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 - No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A
completely filled in by the fi Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

only one 29b. Signature and title of certif

31. Date filed (Month, Day,

NOV 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D005333

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Doath Physician/ Month 10 DM Medical Examiner 4a. Facility Name (if not institution, give street and Town, or Location of Death unty of Death Age (In yrs. last birthday) 80 Yrs. If Under 24 H/s 8 Date of Birth Birthplace (State or oreign Country) **Funeral** 214 30 0749 Months Hours Min Director 1932 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director St. Mary's Lexington Park MD 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 18440 Three Notch Road 20653 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 954-60 1 Yes 2 No Specify: 3 Nidowed 4 □ Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene.

27 is marked other than "I raumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Government Motor Vehicle Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Samuel C. Taylor, Sr. Mary L. Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 301 Park Hall, MD 20667 Samuel C. Taylor, Jr. / Brother P.O. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Peter ClaveCem. 11/16/2012 St.Iniques,MD 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Sign of Funeral Service 38576 Brett Way Mechanicsville,MD 20659 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Year i signed by the a ld be detached fo 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director. After this certificate has k
d in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🔼 No 잍 1 Inpatient 2 I 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. gedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 4:30 AM Ĺ homas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Elder Care Anne Arundel Severna Park Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Min. 186-32-5964 Director 1 🗆 M 2 🕟 69 1943 Pennsylvania May 1, "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Crofton 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2088 Pawlet Drive 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours iment of Health and Mental Hyglene. fant: If Item 27 is marked other than "natur jury or other traumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Martinkovic Anna Mary Divorsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie A. Bowling / Daughter 2562 Windy Oak Court, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1
Department of Important: If it any injury or o 1 Burial 2 A Cremation 3 Removal from State Metropolitan Crematory :11/17/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 2 HN 1 🔲 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suícide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Or MES Highway 30. Name and address of person wno completed cause of death (Item 23a) Type, Print)

DHMH 17 Rev 06-2011

State Registrar UNEUT G

31. Date filed (Month, Day

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Registrar's Signariere

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Winder November Medical Facility Name (il not institution, give street and number) 48, City, Town, or Location of Peath **Examiner** 4c. County of Death Baltimore Cit Social Security Number 7. Age (In yis. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 009-26-2070 Hours June 11, Year 1937 **Director** 1 M 2 TF 75 Connecticut 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Pennsylvania Perry County New Bloomfield, 1 🗆 Yes axx No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Pike Road 17068 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard D. Langdon Mary T. Tutts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr James A. Wingert 500 Pike Road, New Bloomfield, Pennsylvania 17068 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial **2 TV** Cremation **3** Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory: LLC Carisle, Pennsylvania 21. Signature of Funeral Service (icensee 23. Part 1. Enter the disease, or complications that caused the pear. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) 22. Name and Address of Facility M-008491 17268 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Mellmonta disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury Division work? 1 ☐ Yes 2 ☐ No s after death. Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ne and address of person who completed cause of death (Item 23a) (Type atherine MITTIM State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Year) 959 Months Hours March 5 Min. Country) Maryland Director 213-78-5506 1 □ M 2 X 1 F 53 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 7956 Innkeeper Dr. 21144 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Il Hygiene. other than "natural", or ğ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nationwide College (1-4 or 5+) Elementary/Secondary (0-12) 12th 4yrs Claims Manager Insurance Co. Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Joseph White Sr Amelia Grandy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Nathaniel Charles (Husband) 110 Chartsey St. Upper Marlboro, Md. Baltimore, Place of Disposition (Varyo of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Memorial Park 11-15-12 Glen Burnie, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Miname are see seof secilitisons Mortuary, P.A. Lavy 1922 Forest Dr. Annapolis, Md. 21401 MAS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. otage RENALDISEAS Immediate Cause (Final Onset and Death END Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death ed by the a detached 1 9 Unknown been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 1 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No 6 Dother Specify n'ent hospire မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manuar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

5 213

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Whitt Merle J Month 11 201° 2 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 01/23/1916 **Director** 96 214-26-3838 <u>Columbus</u> Ohio Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Waldorf 1 Tyes 2X No Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20602 4554 Ryan Place, Unit C 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1X Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 🕅 Widowed 4 □ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) artment of Health and Mental Hygiene.
cortant: If item 27 is marked other than
injury or other traumatic event, the Me. Life Insurance Elementary/Seconday (0-12) College (1-4 or 5+) Company Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Agnes Olivia Glenn Charles Alfred Whitt Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waldorf, Maryland 20601 4826 Bryantown Road <u>Noah Lee Weinberger</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2012 Suitland, Maryland Washington National per it.
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any inju Signature of Funeral Service Licensee 22. Name and Address of FacilitBrinsfield-Echols Funeral Home, P. A. M00817 MD 20622 30195 Three Notch Road Charlotte Hall, Tehol 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use or the beat ached. Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ∐ Yes ∠ □ □ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MOMIC KIDNEY DISEASE 1 Yes 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy PU/months performed After this certificate 1 ☐ Yes 2 ☐ No Be Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Tes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WOV. 2012 ress of person who completed cause of death (Item 23a) (Type, Print) Stephen P. Cafferty 100 Hospital Road Prince Frederick, MD 20678 10+1 Registrar's Signature 31. Date filed (Month, Day, Year) 32. State NOV 2 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

urt Lancaster Wil			ate of Maryla	nd / Depa	artmen		alth and	Menta	al Hy	giene	20	112 3208		
Physician	R:	egistrar . Decedent's Name (First, Middle	Last)		Timeate	01 000		**	2	2. Date of Death		3. Time of Death		
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***		Fort Washington Hos	Medical	Cente	r		Washin		Odbles	le Data of Birt	Prince G	eorge's 9. Birthplace (State or		
Funeral Director		Social Security Number $42-48-3789$	6. Sex	7. Age (In yrs. 63	last birthda	_	nder 1 Year oths Days		Min.	7/13/	,	Foreign Jamaica Country)		
kus	Ī	Usual Residence of Decedent Oa. State 10b. County		Inc. City	, Town or I	ocation						10d. Inside City Limits		
) <u>*</u> .		MD Char	les		aldo							1 Yes 2 No		
the Maryli a or 28a-f tified at o	MD Charles Waldori 10e. Street and Number 10f. Zip Code 20603 10 612 Knollwood Court 20603 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc.) 14. Race - Armod Forence 2000 (No. 14. Race - Armod Forence 2000) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc.) 16. Van de Forence 2000 (No. 14. Race - Armod Forence 2000) 17. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc.)								at Country?					
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once TO BO Completed by Firnaral Director		1. Marital Status 1. Never Married 2. Marital Status	If Yes, spe	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.					
nurs afte	<u> </u>	Widowed 4 Diversity Divers	orced If Yes, Give Yea or Dates: hify only highest grad		16a. De	1 Yes	al Occupati	on (Give ki	nd of wo	ork done	16b. Kind of Bus	Black siness/Industry		
5-0036 ed within 72 hour sygiene. other than "natt	during most of working life. DO NOT use retired) 12th College (1-4 or 5+) Forklift Operator								Bakery					
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical.	2	17. Father's Name (First, Middle, Last) Leslie Wilson 18. Mother's Name (First, Middle, Maiden Surname) Alethea Garrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,												
and 2 should leath and Me tem 27 is ma traumatic co	2	19a. Informant's Name/Relations Kathleen I.	wilson/w	wife	196. 1	Mailing Addr 612 Kr	oss (Stree	od Ct	erorRu Wa	aldorf,	MD 2060)3		
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through Gourses 12											ldorf, M			
Physician /Medical ixaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Hypert e	ensive	Ather							Between Onset and Death		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burning of the complete of the control of the		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	1 Live b	nant at time of	2	Fetal dea		Ectopic	pregnar	ncy	23d. Date of Month	Day Year		
P.O. Bo that the dea		Part II. Other significant condit	9 OHKIK		resulting in	n the underly	ing cause o	iven in Par	t i.	23e. Did to	obacco use contri	bute to the cause of death?		
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ital Fician: ician: s certific	ğ	25. Was case referred to medica examiner?	100	Inpatient 2	₽ ER/Outr	nationt 3	26.Place	of Death (Residence 6	Other		
nding Physical After this funeral direction	- LO	1 ✓ Yes 2 No 27. Manner of Death 1 ※ Natural 5 Pend	28a. Date (Month	of Injury h, Day,Year)	<u> </u>	ne of Injury	28c. Inju	ry at Work?	7		how injury occurr			
Divisic tal or Atte is after dea al Directo led in by th	Certification:	3 Suicide 6 Cou	d not be rmined (Specify)	ce of Injury - At	home, farn	n, street, fac	ory, office t	ouilding, etc).	28f. Location (3 or Town, S		er or Rural Route Number, City		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time of the desired of the desire														
_	29b. Signature and title of certifier 29c. License number O.C.M.E. November 25,									ed (Month, Day, Year)				
● by	-	Therdon U				. Δ.					1			
	-	Theodore M. King, Jr.	, MD. Assista	ant Medical	Examin	er 900	W. Baltir	nore Stre	eet, Ba	altimore, MI	D 21223			
Sta Registr	te	31. Date filed (Month, Day Year)	8 2012	2 ages of Sight	A.C. G	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Day 2012 Alan Edward Walker 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Coastal Hospice at the L Wicamica Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 187-30-8372 74 Director 1 ☑ M 2 □ F 3-13**-**1938 PA other then "natural", or items 23a or 28e-f show rent, the Madical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Ocean Pines Worcester 1 A Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 18 Carnegie Place USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. δ 1∑ Yes 2 ☐ No If Yes, Give White 1 ☐ Yes 2 ☒ No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Military Colonel U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward E. Walker Mildred F. Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth D. Walker - Spouse 18 Carnegie Place, Ocean Pines, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of Importent: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem.: 11-12-12 Millsboro, DE 21. Signature of Funeral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William Street, Berlin, MD. 21811 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nech Head Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of): sate has been signed by the attending physician end page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death. erel Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifies 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence State (Specify) However 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOGE SH VOHRA SALISBURY, MD 21804 TIO EASTERN SHORE

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

DN 20+1

w

32. Registrar's Signature

DR.

			For State	State of Mary	rland / Depa	artmer		ealth and I		_	12 38985		
	Dhuaisia		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncau	e or D	eain	2. Date of Dear	Reg. No. L. U	3. Time of Death		
	Physicia Medic	al .	Vanessa D. Watson 4a. Facility Name (if not institution, give sti			41- 01-	Town out		Month	24	2812 0215A M		
	Examin	er	RININSULA REGIONAL					ocation of Death			of Death .		
	Funeral Director		5. Social Security Number 6. Sex 216–74–6803 1 □ Usual Residence of Decedent	7. Age (In 54	Hours Min.	8. Date of Birth Month, Day Sept 22	Date of Birth 9. Birthplace (State or Fore Country) MD						
	/land f show	tor	10a. State 10b. County		c. City, Town or Lo						10d. Inside City Limits		
	or 28a- notifie	Direc	MD Wicomico 10e. Street and Number		Salisbury	7 10f. Zij	n Code			10a Ciina -41	1 ☒ Yes 2 ☐ No ten of What Country?		
	with the s 23a c	Funeral Director	1015 Kent Avenue				1801	reg. onzor or vital obditay.					
9036	e filed within 72 h. urs after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever of Armed Forces? 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates.	Yes, spe	dent of His cify Cuban 2X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. Black			
21215-0036	ithin 72 horiene. Iene. r than "nat	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4 or 5+)		kind of wo O NOT us	rk done du e retired)	tion wing most of work Sitter					
Maryland 2		To Be	17. Father's Name (First, Middle, Last) Bobby Lee Watson						e (First, Middle, M Ers				
, Mar	shou and is n		19a. Informant's Name/Relationship (Type Crystal Watson/dau		ddress (Street and Number or Rural Route Number, City or Town, State, Zip mont Avenue, Salisbury, MD 21801								
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any njury or other ti		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	0b. Place of Dispo cemeters cron Snow Hill Church	Tener Ceme	ther place iveral cery	hce 11/7	Date /2012	Snow H	- City or Town, State		
Ball	Departing Departing Important Import	Ц	21. Signature of Funeral Service Licenses	atsin	22 I 1	Name ar ÆWIS 618	nd Address N. W West	of Facility atson Fu Rd., Sal	neral Ho isbury,	me, PA MD 2180)1		
	Physician/ Medical Examiner	S. 5	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line. Due to (or as a cor	/A	er the mod	le of dying,	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	cuted nd nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of): Due to (or as a consequence of):									
09/	cate be executed physician and s the burial-transit	cal											
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ds, P.O	quires that t en signed b cuid be deta	ρλ	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the u	nderlying	cause give	n in Part I.		e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown			
Division of Vital Records, P.O.	: The law red cate has bed r, page 2 sho	Completed							24a. Was ar autops perfor 1 Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
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on of	anding Phy ath. rr: After this	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time of		28c. Injury a work?	at	ome 5 🗌 Reside 28d. Describe ho				
Divisi	ital or Atte urs after de rai Directo lled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director.	Medical	only one) 3 Certifying Nurse I	: On the basis of examine	nation and/or invest	igation, in death occ	my opinion urred at the	, death occurred a e time, date and pl	t the time, date an	d place, and due	e to the cause(s) and manner stated.		
	ច្ច		29b. Signature and title of pertifier		>		Dela 1				d (Month, Day, Year)		
U	37		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type, P	rint)	142	777		107	51/12		
	4			bars, Mo	10	DO E	CARRO	11 57.	SALIS	641/ 11	10 21801		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD BAISAIS, MD 100 E LAKKON ST. SALISBUY MD State Registrar Registrar													

12-08416 Jerome Vorden Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifi	ficate of D		id Michial I	-	eg. No. 2012	38986
Physici edical Exami			th	3. Time of Death					
	mer	Jerome Vorden Wood 4a. Facility Name (if not institution, give stree	t and number)	14b	City Town o	r Location of Deat	Month Novembe	r 6, 2012 4c. County of Death	1046 hrs
		Baltimore Washington Medical			en Burni	,			
Funeral Director		5. Social Security Number 6. Sex 231 11 6769	7. Age (In yrs. last t		f Under 1 Ye Months Da		n.	rth(MM/DD/YYYY) 9. Bir Foreig	thplace (State or on Virginia
		Usual Residence of Decedent	2 <u> </u>	Yrs.			04/30	/1967 00	untity): 1 5 1 11 1 4
v any		10a. State 10b. County	**	wn or Location					10d. Inside City Limits
Maryland 28a-f show i at once.	tor	VA	Lync	hburg					1 Transport Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	107. Dage Street		10	of. Zip Code 2450	1		Og. Citizen of What Cou United Stat	•
with th	Tal [107 Page Street 11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was D		L ispanic Origin?(S			ican Indian, Black,
death or iten	Funeral	1	Armed Forces? Yes 2 🖈 No	If Yes,	specify Cuba	n, Mexican, Puert	o Rican, etc.)	White, etc.	
rs after rral",	Š	3 Widowed 4 Divorced If Yes, or Dat 15. Decedent's Education (Specify only high	ae.		s 2 No	specify: ation (Give kind of	tunde dono	Specify: B1a	
72 hour	eted		ollege (1-4 or 5+)			e. DO NOT use re		Tob. Kind of Business/	industry
0036 within ene.	Completed	12th		Truck I	river			Stericyc1	.e
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c evect, the Medica	Be Co	17. Father's Name (First, Middle, Last) Welford Wood Jr.				18.Mother's Nam Janice		Maiden Surname)	
212 hould be nd Ment is mark	To B	19a. Informant's Name/Relationship (Type, Pr	rint)	19b. Mailing Ac	Idress (Stre			nber, City or Town, State	, Zip Code)
B, MD and 2 sho fealth and item 27 is traumati		Donna M. Wood						, Maryland	21113
E 5 5 5	Г		moval from State crem	natory or other	place)	·	Date /17/2011	20c. Location - City or	·
Baltimo	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Heri	itage C	e and Addres			Lynchburg,	
Per Per diji		Lucer Smil	Skel			. 10		hines Funer	al Home 0011
Physician /Medical		23a. Paz 1. Enter the disease, or complication failure. List only one cause on each line							Approximate Interval Between Onset and
Examiner			Wound of Chest (or as a consequence of):		*				Death
-/		Sequentially list conditions, b.	(or as a consequence or).						
	niner	if any, leading to immediate Due to cause. Enter Underlying Cause	(or as a consequence of):						
ed nsit	Examine	CVOING FOODERING IN COCKET) East	(or as a consequence of):						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	dUNPENDED AME	NDED						
760, icate be physic the bur		IF FEMALE: 23c. 23b. Was decedent pregnant in the	. If yes, outcome of pregnand	су				23d. Date of deliver	,
Box 687 e death certific the attending p ed for use as th	cian	past 12 months?	Live birth Pregnant at time of death	2 Fetal of	(Specify)	Ectopic pregn	ancy	Month [Day Year
Box 687 ne death certific. the attending p	Physician/	1 Yes 2 No 9 Unknown 9	Unknown					i.	
P.O.	by P	Part II. Other significant conditions contri	buting to death but not result	Iting in the unde	rlying cause	given in Part I.		obacco use contribute to s 2 ✓ No 3 ☐ Prot	
ords, P.C. w requires that as been signed is should be deta	Completed	M. The state of th					24a. Was	an 24b. Were au	topsy findings available
e law re has te has te ge 2 sh	ğ						autor perfo 1 ✓ Yes	rmed? death?	completion of cause of
Vital Rec ysician: The this certificate director, page	Be Co	25. Was case referred to medical			26.Plac	e of Death (Check		2 No 1 Ye	es 2 No
n of Vital I ding Physician: h. After this certifit funeral director,	To B	examiner? 1 ✓ Yes 2 No	I Inpatient 2 ER	<u> </u>			ng Home 5	Residence 6 Other	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Pending N	(Month Day Year)	lb. Time of Injur 200 hrs	' '	ury at Work? Yes 2 ✔ No	28d. Describe Subject stal	how injury occurred	
/iSiC r Atter ter dea irector n by th	ficat	2 Accident Investigation	Be. Place of Injury - At home	, farm, street, fa			28f. Location (Street and Number or Ru	ral Route Number, City
Divisor Abours after meral Dire	Certification:	4 Homicide determined	Specify) Single Family	Home			or Town, S 181 Pine Cov	State) e Avenue, Odenton, i	MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b			the best of my knowledge, or basis of examination and/or						
To t To t	Medical	29b. Signature and title of certifier	anner stated.	or investigation,	29c. Licen:		at the time, date	29d. Date signed (Mo.	
		11-	MA		0.0	M.E.		November 7, 20	
3.TM		30. Name and address of person who complete		*	D	04 =			
St	ate	Russell Alexander MD Assis 31. Date filed (Month, Day, Year)	tant Medical Examine		Baltimore	Street, Baltir	nore, MD 21	223	
Regist		NOV - 5 2012	anna B.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Michael Glenn Webb 2012 3:58 РМ November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22412 White Oak Road Leonardtown St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 212-54-5364 **Director** 63 June 20, 1949 New Jersey 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland St. Mary's Leonardtown 1 🗌 Yes 2 🔀 No 10e. Street and Number ò 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 22412 White Oak Road 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) IT Industry Network Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Henry Webb, Jr. Madeline Fracker Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Webb / Son 22412 White Oak Road, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 11/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dire to for as a consectionous of attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy 5 Other (specify) signed by the atter d be detached for a in the past 12 months? Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONFESTIVE Completed 1 Yes 2 No 3 Probably 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, Hospital: 2 40 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending death. 2 Accident Investigation Μ 1 Tes 2 No Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of dertifier 10 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11011/WOOD, M/ 2821 GIL TRINDER MI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PANAGIOTIS ZOUZOULAS November 2012ª 3:11 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Days Hours 578-76-7290 Director 1 X M 2 □ F 67 Nov. Greece Yrs Usual Residence of Decedent 28a-f show 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 ☐ Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5922 Beech Ave. 20817 United States or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black. White, etc þ 1 Never Married 2 X Married ☐ Yes 2 🏋 No Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Meat Cutter Giant Food Stores permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dimitra Papothopoulos Petros Zouzoulas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5922\ Beech\ Ave.\ Bethesda,\ MD\ 20817$ George P. Zouzoulas (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Noy013, Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cem. Signature of Fugeral Service Licens 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Laceration disease or condition pm Medical resulting in death) Due to (or as a consequence of Examiner 36Hrs Acute Blood Loss Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Acute Renal Failure 36Hrs requires that the death certificate be executed and Due to (or as a consequence resulting in death) Last nding physician ause as the burial Physician/Medical 36Hrs Stroke Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Eclopic pregnancy ☐ Other (specify) Month Pregnant at time of death Day Year ed by the a q | Ilnknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performe Yes 2 X No 1 Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: ြ 2 No 1 X Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d Describe how injury occurred
Sitting on toilet, fell in bathtub Natural 5 Pending XAccident 1 Yes 2 X No 11/3/2012 6:30 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rout 210) 8ther filled in by 4 Homicide determined 59220 Beech Ave. Beth. 24 hours a At Home 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier thin 2 the I

DHMH 17 Rev 06-201

State

Registrar

31. Date filed (Month, Day, Year)

09

PFO

Irving

ause of death (Item 23a) (Type, Print)

Daala3

29d. Date signed (Month, Day, Year)

November 5, 2012

Washington DC 2001D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Bruce Ambrose November 10:10A M Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Columbia Howard 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Months Davs Hours Min. (Month, Day, Year) Director 1 M 2 F 216-30-1913 79 November 29,1933 Maryland Page 1 and 2 should be filed within 72 hours and 2 should be filed within 72 hours and 1 health and Mental Hygiene.
Thentof Health and Mental Hygiene.
Thentof Health and Mental Hygiene.
The marked other than "natural", or items 23a or 28a-f show that: If item 27 is marked other than "natural", or items 23a or 28a-f show that: If item 27 is marked other than "natural", or items 23a or 28a-f show that it is marked of the 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane Apt 321 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Principal Prince George County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Perry Rutherford Ambrose Rose Marie Stegmaier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ambrose permit, Page 1 and 2 Department of Health Important: If item 2; any Injury or other to (Son) 13901 Bottom Road Hydes, Maryland 21082 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Ceretery 12-5-2012 Clinton, Maryland 21. Signatura of Funeral Same Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. M0105 Thede V 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ischemic Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 🗵 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris 6334 Cedar Lane #103 Columbia, Maryland 21044 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month À11en Richard Timothy November 11:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Renaissance Gardens at Oak Crest Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Months Days Min (Month, Day, Year) Director 214-66-6961 1 X M 2 □ F 70 Feb 27, 1942 Maryland Usual Residence of Deceder ir then "neture!", or itema 23e or 28e-f ahow the Medical Examiner must be notified at 10a. State 10c. City, Town or Location death with the Merylend 10d. Inside City Limits Director 1 Yes 2 X No Parkville Marvland | Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8800 Walther Blvd. 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours efter If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Pege 1 and 2 should be flied within 72 Department of Heelth and Mentel Hygiene. Importent: If item 27 is marked other then any injury or other traumetic event, the Ma life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a n/a Laborer Food Service 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Allen Doris Madeline McNulty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Dvorak/Cousin CTLang Road, Windsor, 06095 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, Maryland 12/4/2012 Synature of Funeral Service Licens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Clary Bryan 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Priysician/ 69 steet disease or condition resulting in death) Lennox Medical Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of): sicien end buriel-trensit Exami Hospital or Attending Physician: The law requires that the deeth certificete be execu Due to (or as a consequence of): resulting in death) Last ettending physicien for use es the burie Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant at time of death Yes 2 □ No this certificete hes been signed by the readirector, pege 2 should be deteched 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Retardation, Encephalopathy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be

Division of Vital Records, P.O. To the Hospital or Attending Physician; I within 24 hours efter deeth.

To the Funeral Diractor: After this certifics completely filled in by the funeral director, I

State

Medical

29a. Certifier

only one)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Parkville MO 21234

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

pleted cause of death (Item 23a) (Type, Print)

determined

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

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	• -	-	For State	state of Maryland / D		nt of Health and I te <i>of Death</i>	2011	2 38991						
	DI		Registrar 1. Decedent's Name (First, Middle, Last		- Cortimout	or Dourn	2. Date of De		3. Time of Death					
	Physicia Medic	al	Anthony, B	aker	1		Month 2	2 20°						
پ امس	Examin	er	4a. Facility Name (if not institution, give s	street and number)	4b. City	Fown, or Location of Death		4c, County of	Death					
	Funeral		5. Social Security Number 6. Se	ZM O DE		Birthplace (State or Foreign Country								
	Director		Usual Residence of Decedent	SL.	21960	January HD								
	f shov	tor	10a. State 10b. County	10c City, Town					10d. Inside City Limits					
:	r 28a- notifie	Direc	10e. Street and Number	Bultin	1010 101 71	n Code	1	10g. Citizen of Wha	1 Yes 2 No					
:	should be filed within 72 hours after death with the Maryland and Merital Hygiene. I and Memtal Hygiene it is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	Funeral Director	501 Preston St.	Apt. 129	ø(1202		USA	4					
:	death ritems inerm		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece If Yes, spe	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.					
036	s after ral", o Exami	ed by	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 🔲 Yes 2 💆 No If Yes, Glve Year or Dates.	1 🗆 Yes	2 No Specify:		Specify:	Black					
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2	1 and 2 of Health fitem 27 other to		19a Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip of Towarda Baker - Anather - Anather State, Zip of Towarda Baker - Anather - Anat											
ore,			20a. Method of Disposition 1 Burial 2 Cremation 3		Disposition (Na y, crematory		Date	20c. Location - Ci						
<u>#</u>	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Mr. Carme Cemetery 12-6-12 Durdalk, mb 21. Signature of Funeral Service Liberalee											
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	hytician/ Medical	9	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											
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687	ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	TIII—A			23d. Date of	of delivery					
Box 68760<	reatter ed for u	sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic 5 Other (s			Month						
P.O.	d by th		9 ☐ Unknown Part II. Other significant conditions co		n the underlying	cause given in Part I.	23e Did t	obacco use contribu	te to the cause of death?					
S,	signe Id be o	Completed by	Lung Cana						Probably 4 Unknown					
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lita	certific irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		26. Place of Death (Chec			2 1/1					
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Division of Vital	al or Attending Files after death. I Director: After the in by the funeral		4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, facto	y, office	28f. Location (S City or Tov		r Rural Route Number,					
-	To the hospital or Attended in Wistorian, the law requires that the beauthost the beauthost be within 24 burst after death. To the Puneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical		ician: To the best of my knowledge, oner: On the basis of examination and/or										
-	o the F o the F omplet	Me	only one) 3 Certifying Nurse	e Practioner: To the best of my knowle	edge, death occi	urred at the time, date and pla	ce, and due to th	ne cause(s) and mann	er as stated.					
	- s F ő		Aus a	nlusan		00677	58	12/2/	12					
	3		30. Name and address of person who co	ompleted cause of death (Item 23a) (1	Type Print)	01 2	N 1-	- / /						
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	· Van	14 lace >	mpla	NOT L						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30, 2012 Physician/ Month Douglas Aclev Brown 8:00 PM November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore 1000 E. Joppa Road, Apt 211 Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Country 78 214-30-6503 Director 1 🛣 M 2 🗆 F Maryland March 19,1934 ral", or items 23e or 28e-f ehow Examiner mut be notified at 10a. State 10b. County and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. tem 27 is marked other than "netural", or items 23e or 28e-f eho 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Baltimore Towson 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 1000 E. Joppa Road, Apt 211 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 122XYes 2 ☐ No If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ဩ No Specify: 3 Divorced Specify White Completed Year or Dates th and Mental Hygiene. 27 is marked other than "netur traumetic event, it a Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Draftsman Bendix Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Hilliard Brown Helen Elizabeth Olander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Smith - Sister 8810 Walther Blvd, Apt 2023, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Pege 1 Department of Important: If It any Injury or o 1 Burial 2XXCremation 3 Removal from State Evars Fureral Charles and Dec 3,2012 4 Donation 5 Other (Specify) Forest Hill, MD Cremetion Services-Adair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physicien end d be deteched for use as the burlel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificete be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobageo use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has baen significate has baen significated funerel director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours efter daeth. Funeral Director: After this certifics Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one 1 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours or the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0 2 ess of person who completed cause of death (Item 23a) (Type, Print) 79 $\Lambda \Lambda$ 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 999 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 George E. Brooks Jr. Dec. 1:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ivy Hall Nursing Center Middle River Baltimore 8. Date of Birth (Month, Day, Year) Nov. 25, 1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 214-26-1993 Hours Country) Director 1**X** M 2 □ F 82 rai", or iteme 23e or 28e-f ehov Examiner nust be notified at I end 2 should be filed within 72 hours eftar deeth with the Meryland Fleeth and Mental Hyglene. If Heeth and Mental Hyglene teams are 22 or 28e-f abouter treumetic event, the Modical Examiner must be notified as other treumetic event, the Modical Examiner. 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Essex Baltimore 1 Yes 2 No 10e. Street and Number 271 South Eastern Terrace 10f. Zip Code 10g. Citizen of What Country? 21221 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker 11th Beth Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George E. Brooks Sr. Edna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Waggoner /daughter 948 Thompson Blvd. Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Pege 1 20c. Location - City or Town, Sta parmit. Pege 1 Depertment of Important: If it any injury or o Bayview Crematory 12/4/12 1 Burial 2 X Cremation 3 Removal from State Baltimore MD 4 Donatton 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition dvanced Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): spitel or Attending Physicien: The lew requires that the death cartificate be executed ours after death. I sertificate hes been signed by the ettending physician end illed in by the funerel director, page 2 should ba deteched for use as the burlai-transi. Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arten 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 ANO 1 Yes 2 No Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) ၉ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospitel o within 24 hours af To the Funerel DI completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0063176 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 201

Ballar

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of M	arylan	d / Depa	artmen	t of H	lealth a	and M	lental Hy	giene	- O 1	13	0 2 2 0	1
			State Registrar				Cer	tificate	of D	eath			Reg. No.	201	2	3899	4
	1. Decedent's Name (First, Middle, Last) Physician/ Rosalie F. Bonhardi										2. Date of De		Xe	ear_	3. Time of Death		
	Medic	al											Ï2	10:20 A.M	1		
	4a. Facility Name (if not institution, give street and number) Charlestown Care Center									Location of ille	f Death		4c. County of Death Baltimore				
	Funeval		5. Social Security Number	6. Sex		ne (In vrs. la	ast birthday)	If Under		If Under 2	24 Hrs.	8. Date of Bir	th			lace (State or Foreig	an a
	Funeral Director		212-14-2742] M 2 X F		Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Count	try)	
	M.		Usual Residence of Decedent	_		93						Nov. 8	, 19.	19	Oh		
	yland f show ed at	ţċ	10a. State 10b. Cour			·	y, Town or Lo								10	0d. Inside City Limits	
	- 28a-	Director	MD E	Balti	more	Cat	onsvil	.1e 10f. Zip	Cada				40. 000	14(h-	1000		10
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	ath w	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S	S. 13. V	Nas Deced			in? (Spe	cify Yes or No-	1	4. Race - /	America	an Indian.	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	اج	1 X Never Married 2 Nover Marr		Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			f Yes, spec	ify Cubar	n, Mexican,	Puerto	Rićan, etc.)		Black, V		etc.	
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Maryland	ould nd Me marl mati		19a. Informant's Name/Relatio		oe, Print)	_	19b. Mailii	na Address				l Route Numbe	_	Town, State	e, Zip C	code)	7
	12 sh alth ai 27 is rr trau		Thomas Bonhar									dersbur				·	
ē,	1 and of Heal item (20a. Method of Disposition		- 44		lace of Dispo emetery, crer	sition (Nan	ne of ther place	۵)	[Date	20c. Lo	cation - Cit	y or To	wn, State	
m _C	Page 1. ment of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe			Mor	eland	Mem.	Ceme	tery				timor			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Finer Service	e Lucinse	e		22	Name an	d Addres	s of Facility	Ste	rling A	shto	n Sch	wab	Witzke D 21228	
ш	20 E # 9		INC		HO		1.1	630 F	dmor	idson	Ave	nue; Ca	tons	ville	, M		_
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or compl st only on	ications that cause e cause on each lir	d the death e.	h. Do not ent	er the mode	e of dying	g, such as c	cardiac d	r respiratory ar	rest,			Approximate Interval Between Onset and Death	
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Y	Medical Examiner		resulting in death)		Due to (or as	a cons	ence of):										
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87	rtifica ing pl	Me	IF FEMALE:														
Box 687	ath ce	ian	23b. Was decedent pregnant in the past 12 months?		3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant	2 Feta	al death 3	Ectopic p	oregnanc	У			23d. Date of delivery Month Day Yes				
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P.O.	requires that the death certifica been signed by the attending pl should be detached for use as t		Part II. Other significant cond	litions co	ntributing to death	but not res	ulting in the	underlying	cause giv	en in Part I	ı .	23e. Did t	obacco us	se contribu	ite to th	ne cause of death?	
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₹	hysic his ce al dire	၉	1 ☐ Yes 2 ☐ No				ER/Outpatie			4 L4 Nu		me 5 Resi			Specify)	
Jo C	ing P I. Viter t funera	ate:	27. Manner of Death 1 Natural 5 Per	nding	28a. Date of inj (Month, Da	ury a <i>y, Year)</i>	28b. Time o injury		8c. Injury work	?	- 1	28d. Describe	how injury	occurred			
Sior	death.	Certificate:	3 Suicide 6 Cou	estigation uld not be	28e. Place of In	iuny - At bo	ome form sti	M eet facton		Yes 2	No	28f Location /	Street and	l Number o	r Rural	Route Number,	-
Division of Vital Records,	pital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director,		4 Homicide dete	ermined		tc. (Specify		cot, ractor,	r, Omoc			City or To		rivanioci c	7 71010	rioute runnou,	
	spita hours neral y filled	ical	29a. Certifier 1 Certify	ing Physi	ician: To the best o	f my knowl	ledge, death	occurred a	t the time	e, date and	place, a	nd due to the c	ause(s) an	nd manner	as state	ed.	
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placement of the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Medical	(Check 2 Medica	al Examin	er: On the basis of e Practitioner: To t	examination	n and/or inves	tigation, in	my opinic	n, death oc	curred a	t the time, date	and place,	and due to	the cau	use(s) and manner sta	ated.
	Vith Com		29b. Signature and title of cert	ifier				290		number	-7			e signed (A		Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorthy Ann Blair 58 AM Physician/ Month 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Hospital Center -Ranklin If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Country) 215-48-2054 95 Director 1 □ M XX F MD August 10,1917 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Parkville Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8800 Walther Blvd #320 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Specify: White Maryland 21275-0036 Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 XXNo Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 's any Injury or other traumatic event, the Meany Injury or other traumatic event, the Meany Dines. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ward Anna Gluth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Blair (Son) 910 Southerly Road Apt 342 Towson, MD 21204 Baltimore, 1 aie, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Memorial 1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/6/12 Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc 21. Signature of Funeral Service Licenses 10 West Padonia Road Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Imor that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 <Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 4 Pregnant : 9 Unknown Day Pregnant at time of death 5 Other (specify) ector: After this certificate has been signed by the by the funeral director, page 2 should be detached Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 N 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျှ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work?
1 Yes 2 No Accident Investigation after deat Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours after e Funeral Dire Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Baltimore MD tranklin Savare Jaipeen 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ann Marie Bobich 9:02 2012 Ам November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7 Ivey Trace Drive Cockeysville Baltimore 11/28/201 5. Social Security Numbe Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Months Days Hours June 9, 1916 Director 210-34-9752 96 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director York 1 Yes 2 No Shrewsbury DOD: 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 51 W. Clearview Dr. 17361 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 and Mental Hygiene.
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Holy Trinity
Serbian Orthodox Cem. 1 🗆 Burial 2 🗆 Cremation 3 ីX Removal from State 4 Donation 5 Other (Specify) 2012 Pittsburgh, PA 21. Signature of Fundaria Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road Timonium, MD 210 Michael J. **Y**lagle 23a. Part 1. Enter the disease applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ renal disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Director; After this certific
I in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's Hospital Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Theside e 6 😾 Other (Specif 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) Signature and title of certifier 29c. License number annence 11-28-2012 D030122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Osler Dr., Suite 411 Dr. Lawrence Snyder, M.D. Towson, MD 21204 31. Date filed (Month, Day, Year)

Registrar

12-08855 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey Steven Baynard State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0924 hrs **Medical Examiner** JEFFERY STEVEN BAYNARD November 21, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River **Baltimore County** 3209 Gentian Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign MARYLAND Months Days Hours Director 216-15-4942 1 M 2 F 11-18-1975 37 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No MIDDLE RIVER BALTO. or 28a-f show MD. other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 3209 GENTIAN LANE Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 **X** No WHITE 4 X Divorced 1 Yes 2 X No specify: 3 Widowed f Yes, Give Year Specify: 8 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 MEDICARE COMPUTER ANALYST 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DARLENE HARDESTY traumatic event, If item 27 is marked BRIAN BAYNARD Department of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 37 BANGERT AVENUE PERRY HALL, MD. 21128 MOTHER DARLENE BAYNARD 20a. Method of Disposition

1 Burial 2 A Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 11-28-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY portant: Donation 5 Other Specify 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. /Medical Death Immediate Cause (Final disease a Asphyxia complicating Diazepaw and Alprazolam Intoxication xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical \overline{x} AMENDED #1 as noted, 23a, 27, 28a-f, per me, g934 12-6-12 sm X UNPENDED signed by the attending physician be detached for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed this certificate has been I director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed 2 🔽 No After this certificate Yes 2 V No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other 5 Residence 6 🗹 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 V Yes No funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury subject ingested drugs and ___ Natural 1 Yes 2 X No fd:11-21-12 fd 9:14 am covered his head with plastic bag To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3209 Gentian Ln. Middle River, MD. 3 X Certific 6 Could not be Suicide Residence (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. S **✓ Medical Examiner:**On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E November 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:20 AM John William Beever, Jr. Novembe 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 212-36-9007 1**X** X M 2 □ F 73 2/24/1939 MD Usual Residence of Decedent 28a-f show 10b. Counts 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Anne Arundel 1 Yes 2XXNo Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 501 Kent Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner 14 Race - American Indian Black, White, etc. 1 Never Married XX Married þ Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 Tool Grinder Owner Tools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Beever, Sr. Eleanor Schisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mrs. Anna M. Beever / Wife 501 Kent Road Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 12/4/2012 Glen Burnie, MD Signature of Funeral 22. Name and Address of FacilitySingleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 MOIIZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Chronic obstructive pulmonari and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law has autopsy performed? Yes 2 No certificate director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29c. License number 29d. Date signed (Month. Day, Year) R107529 November 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gren Burnie MD 301 Hospital Brive Howe 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2012 Registrar

Beever

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard S. Bryant State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death **Medical Examiner** Year Richard November 25, 2012 1834 hrs Bryant 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** 9. Birthplace (State or Foreign Washington, Months Days Director 216-40-5758 1 X M 2 F 70 November 12, 1942 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Montgomery Potomac 1 Yes 2 X No death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 10412 Bit And Spur Lane 20854 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? unk 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ≥ 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Owner Rentals Unlimited 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Roswell Abbott Bryant Mildred Elizabeth Cushen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Bryant / Wife 10412 Bit and Spur Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery December 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. 4, 2012 Donation 5 Other Specify: Bethesda, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home/Rockville, Inc. M01305 ette 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva failure. List only one cause on each line /Medical Between Onset and Death a. Atherosclerotic Cardiovascular Disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has b 2 sh autopsy performed? death? certificate Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other this ဥ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City

To the Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: d in by the Medical

State Registra

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

29b. Signature and title of certifier

3 Suicide

Homicide 29a. Certifier 1

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

(Specify)

and manner stated.

Could not be

30. Name and address of person who completed cause of death (Item 23a)

YUHHUL

29d. Date signed (Month, Day, Year)

November 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ivia	-	Certificat				Reg. No.	12	39000		
	Physicia		Decedent's Name (First, Middle, Last Richard John	•	Sr.				2. Date of Dea		Ž₩12	3. Time of Death 8:26A M		
	Medic Examin		4a. Facility Name (if not institution, give Frederick Μεπ	street and number)			Town, or l	Location of De	eath	4c. County	of Death	k		
	Funeral		5. Social Security Number 6. S		In yrs. last birtha		r 1 Year	If Under 24 H		h	g. Birthplace (Sta			
	Director		579-40-7014 Usual Residence of Decedent	<mark>М</mark> м 2□ F	82 Yr		Days	Hours M	in. (Month, Day June 10), 1930	Ohio			
	rryland a-f shov	Director	10a. State 10b. County Maryland Freder		10c. City, Town o	r Location rovia					10	d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	e or 28		10e. Street and Number			10f. Zij				10g. Citizen of W		ry?		
	eath with	Funeral	4345 Ed McClain	12. Was Decedent Eve	er in U.S.	13. Was Dece	217 dent of His		(Specify Yes or No- erto Rican, etc.)	United 14. Race	State - America			
36	1 and 2 should be filed within 72 hours efter death with the Maryland if Health and Mentel Hygiene. If Health and Mentel Hygiene. If merked other then "neturel", or items 23e or 28e-f show other traumetic event, the Medical Evantiner must be not item at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	0	If Yes, spe			erto Rican, etc.)	Blaci Specify:	k, White, et Whit			
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land	l be filed lentel H rked otl	To Be	17. Father's Name (First, Middle, Last) Maurice Franklin	Benton						Middle, Maiden Surname) Millison				
Maryland 21215-0036	2 should th and Me 27 is mer traumeti		19a. Informant's Name/Relationship (7) Richard J. Bentor			-				· •	or Town, State, Zip Code)			
	permit. Pege 1 end 3 Department of Healt Important: If item 2 any injury or other once.	20a. Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other Cate of Heaven Cemetery)							Date	20c. Location -	City or Tow	vn, State		
Baltimore,	nit. Pege lartment c lortant: If injury or le.		4 ☐ Donation 5 ☐ Other (Special Service License	fy)	Gate of H			: -	cember	Silver Sp				
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	Medical Examiner		resulting in death)	a. Due to (or as a	consequence of)	446	60	queve	SCUIAV	4/50	26	TCRVS		
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160	icete be executed j physicien and s the burial-transi	Aedical		d							\pm			
89 x	requires that the death certific been signed by the ettending should be deteched for use es	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death	3 Ectopic		<i>y</i>		23d. Date of delivery Month Day Year		y Day Year		
P.O. Box 68	the dea by the e teched t	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ U <i>n</i> known	4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown										
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cord	lew requires been serviced as been serviced as been serviced as the serviced a	Completed by							24a. Was	osy p	rior to com	sy findings available apletion of cause of		
Division of Vital Records,	en: The tificate h tor, page	Be Cor	25. Was case referred to medical				26. Pla	ace of Death (C	perfo 1 Yes Check only one)		eath?	No		
	Physici this cer al direc	욘	examiner? 1 Yes 2 No	Hospital:		patient 3 🗆 D		4 ∐ Nursin	g Home 5 🗆 Resid					
o uo	anding Fath.	Certificate:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio				28c. Injury work? 1 □ `	at ? Yes 2 □ No	28d. Describe h	now injury occurre	d			
ivisi	al or Atte after de Directo d in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			n, street, factor	y, office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural F	Route Number,		
	To the Hospital or Attending Physicien: The lew requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detechnompletely filled in by the funeral director.	Medical		red at the time, date a	and place, and due	to the caus	se(s) and manner stated.							
	To the Within To the comple	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the	best of my knowl		curred at tr		nd place, and due to	29d. Date signed				
	0.4		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	1) =	5/19		Decem	ber	1,2012		
	V Sta	0	Alan Rehrer 131. Date filed (Month, Day, Year)	1) /5 32. Registrar	West	177	7.5%	5. F	reder	rick,	4D	21701		
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